

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Ethel			M. Ainslie			Month Day Year March 15, 1968			6:25p M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		Caucasian		2/10/1893			75 YRS		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH					
New York			U S A						Prince George's			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince Geo. General Hosp.			Retired clerk			U S Gov't					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland				Prince Geo. Landover				YES <input type="checkbox"/> NO <input type="checkbox"/>		8606 St. Johns Place				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
First Middle Last				First Middle Last										
Andrew Ainslie				Franc Weber										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT			Address					
no				577 58 7498		Rose P Waring			Landover, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Acute myocardial infarction of left ventricle and														
DUE TO, OR AS A CONSEQUENCE OF											interseptum 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) Secondary to Right Coronary Artery Thrombus														
DUE TO, OR AS A CONSEQUENCE OF														
(c) Generalized arteriosclerosis, severe											Indeterminable			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from 3/15, 1968, to 3/15, 1968, that (I) (we) last saw the deceased alive on March 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE											22c. DATE SIGNED			
Julius Kauffman											3/16/68			
22d. PHYSICIAN'S NAME (Type)											22e. ADDRESS			
Julius Kauffman, M. D.											6501 Landover Rd., Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			March 18, 1968		Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.						
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons						Hyattsville, Md.			DATE MAR 19 1968		J. Charles Jones			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 Film G399 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4/9/68 kk

04508

# CERTIFICATE OF DEATH

04498

1. DECEASED-NAME (Type or print) <b>Alaric Allen T Allen</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>DOA</b>					
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>12/27/00</b>		6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Ma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA-Prince Geo. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Truck Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>millwork</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Kentland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7204 Forest Rd.</b>		
14. FATHER'S NAME First Middle Last <b>Lang L. Allen</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>June Taylor</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>yes</b> (If yes give war or dates of service) <b>WW II</b>			16b. SOCIAL SECURITY NO. <b>578-03-1263</b>		17. INFORMANT <b>Alice M Allen</b>			Address <b>Kentland, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thrombophlebitis, Left Leg</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of Prostate</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>177X</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hypertensive Cardiovascular Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>3 months</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>March 27, 1968</b> , to <b>21 March 1968</b> , that (I) (we) last saw the deceased alive on <b>27 March 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thomas M. Hutchins</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3-25-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Thomas M. Hutchins, M. D.</b>				22e. ADDRESS <b>7315 Landover Road, Landover, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md. Prince Georges</b>					
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. RECEIVED BY REGISTRAR <b>Mar 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Judge</b>			

THE UNIVERSITY OF CHICAGO  
CHICAGO, ILLINOIS  
JANUARY 1950  
TO THE PRESIDENT OF THE UNIVERSITY OF CHICAGO  
FROM THE DEAN OF THE FACULTY  
SUBJECT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

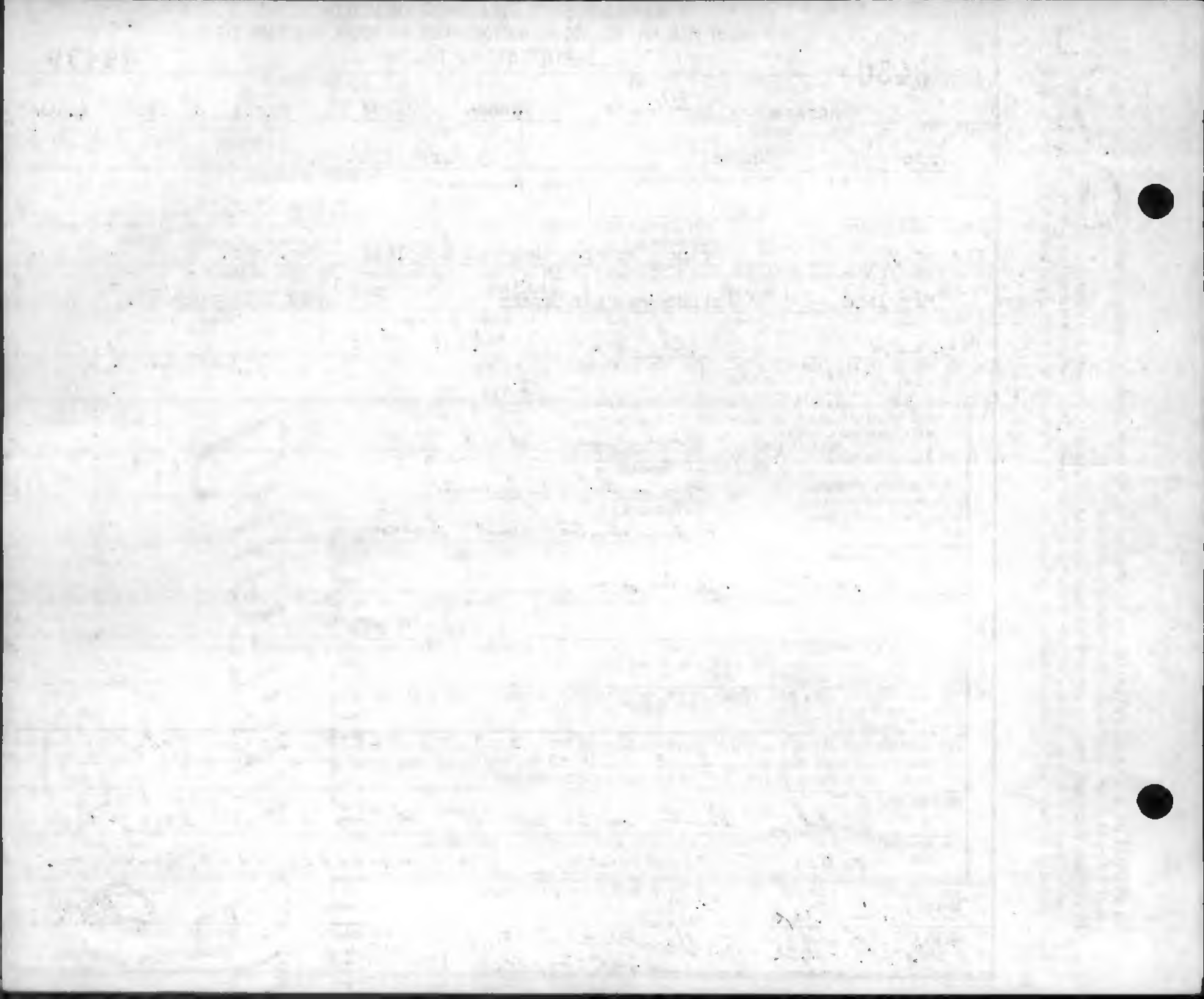
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Horace Willis <del>BYRON</del> ALLEN		2a. DATE OF DEATH Month Day Year Mar., 10 1968		2b. HOUR 4:00A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 13 March 1916	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ter. Mgr.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Lanham	
14. FATHER'S NAME First Middle Last ROLLEN ALLEN		15. MOTHER'S MAIDEN NAME First Middle Last MARIE ROSE		13d. STREET AND NUMBER 9889 Telegraph Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Essential hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-9, 1968, to 3-10, 1968, that (I) (we) last saw the deceased alive on 3-10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Fidel J. Quintana M.D.				22c. DATE SIGNED 3-10-68	
22d. PHYSICIAN'S NAME (Type) FIDEL J. QUINTANA				22e. ADDRESS 12004 MAYCHECK LANE, BOWIE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar 13, 1968		23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW CEMETERY	
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR DATE MAR 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	





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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Baby Boy Averys						Mar. 3 68		1.45A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		2 March 1968		YRS.		13 HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prin. Geo. Gen. Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		P.G.		Forestville		YES <input type="checkbox"/> NO <input type="checkbox"/>		3313 Darlington St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles Everett Averys			Barbara Ruth Wright						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 1300 grams 7720 DUE TO, OR AS A CONSEQUENCE OF (b) Atelectasis of both lungs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Subarachnoid Hemorrhage of right parieto-occipital lobe of cerebrum. 760.5 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) cerebrum.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (husband) attended the deceased from March 2, 1968, to March 3, 1968, that (I) (my) last saw the deceased alive on March 3, 1968, and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE [Signature] 22d. PHYSICIAN'S NAME (Type) Mark Pillor, M.D.								22c. DATE SIGNED March 6, 1968	
22e. ADDRESS 6400 Marlboro Pike, Dist. Hgts, Maryland									
23a. BURIAL, CREMATION, REMOVAL, etc.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		3/16/68		Prince Geo. General Hosp.		Cheverly, Maryland			
24. FUNERAL DIRECTOR [Signature] William A. Parker, Assoc. Administrator						25a. REC'D BY REGISTRAR MAR 19 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

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<div style="display: flex; justify-content: space-between;"> <span>04511</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>04501</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>											
1. DECEASED-NAME (Type or print) <b>Fred</b>			First <b>Fred</b> Middle <b>-</b> Last <b>Bailey</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>68</b>			2b. HOUR <b>7:30</b> MIN <b>A</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8-18-81</b>			6. AGE (In years lost to day) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS <b>-</b> DAYS <b>-</b> HOURS <b>-</b> MIN <b>-</b>		
7a. BIRTHPLACE (State or foreign country) <b>Nebraska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.					
10. CITY OR TOWN OF DEATH <b>Riverdale</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>(Retired)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Meat cutter</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Prince Geo.</b>			13c. CITY OR TOWN <b>Riverdale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6101 44th Pl.</b>	
14. FATHER'S NAME First <b>Jacob D</b> Middle <b>Bailey</b> Last <b>-</b>				15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Gage</b> Last <b>-</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>unknown</b> (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Hospital records Riverdale, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>General arterio sclerosis</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>undetermined</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4500 Gastric ulcer with hemorrhage.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>67</b> , to <b>Mar 31</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>March 30</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>L W Malin MD</b> DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									22c. DATE SIGNED <b>3-31-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>L W MALIN MD</b>									22e. ADDRESS <b>Riverdale, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>April 3, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>APR 9 1968</b>			25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>		

MEDICAL CERTIFICATION



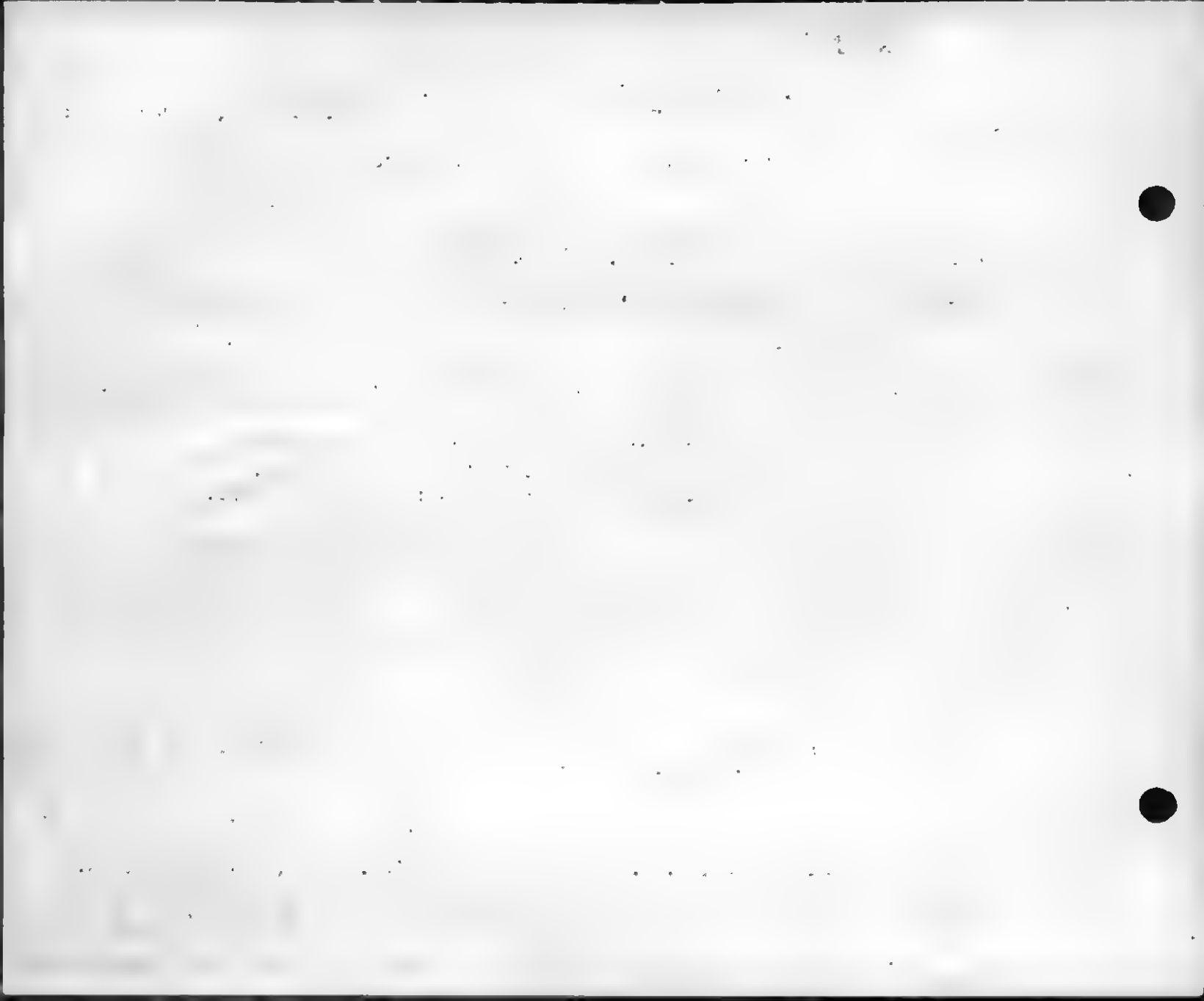
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <b>Mary</b> First <b>E. Baker</b> Middle <b>Sometimes known as</b> Last <b>Sister Gertrude Baker</b>						2a DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1968</b>			2b HOUR <b>9:30 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>May 22, 1882/1881</b>			6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md						
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>			12b KIND OF BUSINESS OR INDUSTRY <b>School</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Prince George's</b>		13c CITY OR TOWN <b>Hyattsville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>5300 43rd Avenue</b>			
14 FATHER'S NAME First Middle Last <b>William P Baker</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Frances Fitzgerald</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <b>218 54 6432</b>		17 INFORMANT <b>Margaret C Walsh</b>				Address <b>Hyattsville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the tail of the Pancreas with metastasis to the Liver.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Thrombo-embolus; right upper lobe.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Feb 7, 1968</b> to <b>March 5, 1968</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>March 5, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (didn't) view the body after death.												
22b. SIGNATURE <b>Aaron Deitz</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3-6-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M. D.</b>						22e. ADDRESS <b>Prince Geo. Plaza, Hyattsville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Notre Dame Reading Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hamilton Butler Ohio</b>					
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN b <b>2 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1166 Neal St., N. E.</b>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>R.</b> Last <b>Banks</b>		4. DATE OF DEATH Month <b>3</b> Day <b>12</b> Year <b>19 68</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/21/1906</b>
9. AGE (In years last birthday) <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Mins.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waitress</b>		12. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Saxton, Pa.</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Dorsey Holmes</b>		16. MOTHER'S MAIDEN NAME <b>Mary A. Robinson</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO. <b>unknown</b>	
19. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, right lung, with wide-spread metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1621</b> (b) DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis cerebrovascular accident with right hemiparesis; left radical mastectomy for carcinoma of the breast, 1940</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>3/8/</b> , 1966, to <b>3/12/</b> , 1968 that (b) (we) last saw the deceased alive on <b>3/12/</b> , 1968, and that death occurred at <b>8:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Glenn Dale</i>		22b. DATE SIGNED <b>3/12/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, (Specify)	23b. DATE THEREOF <b>3-16-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mausoleum</b>	23d. LOCATION (City or Town) (County) (State) <b>Landover Md.</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers &amp; Chapin</b>		25a. REC'D BY REGISTRAR <b>W. W. Chambers</b>	
25b. REGISTRAR'S SIGNATURE <i>W. W. Chambers</i>		DATE <b>MAR 15 1968</b>	



1915

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i, 7j, 7k, 7l, 7m, 7n, 7o, 7p, 7q, 7r, 7s, 7t, 7u, 7v, 7w, 7x, 7y, 7z, 7aa, 7ab, 7ac, 7ad, 7ae, 7af, 7ag, 7ah, 7ai, 7aj, 7ak, 7al, 7am, 7an, 7ao, 7ap, 7aq, 7ar, 7as, 7at, 7au, 7av, 7aw, 7ax, 7ay, 7az, 7ba, 7bb, 7bc, 7bd, 7be, 7bf, 7bg, 7bh, 7bi, 7bj, 7bk, 7bl, 7bm, 7bn, 7bo, 7bp, 7bq, 7br, 7bs, 7bt, 7bu, 7bv, 7bw, 7bx, 7by, 7bz, 7ca, 7cb, 7cc, 7cd, 7ce, 7cf, 7cg, 7ch, 7ci, 7cj, 7ck, 7cl, 7cm, 7cn, 7co, 7cp, 7cq, 7cr, 7cs, 7ct, 7cu, 7cv, 7cw, 7cx, 7cy, 7cz, 7da, 7db, 7dc, 7dd, 7de, 7df, 7dg, 7dh, 7di, 7dj, 7dk, 7dl, 7dm, 7dn, 7do, 7dp, 7dq, 7dr, 7ds, 7dt, 7du, 7dv, 7dw, 7dx, 7dy, 7dz, 7ea, 7eb, 7ec, 7ed, 7ee, 7ef, 7eg, 7eh, 7ei, 7ej, 7ek, 7el, 7em, 7en, 7eo, 7ep, 7eq, 7er, 7es, 7et, 7eu, 7ev, 7ew, 7ex, 7ey, 7ez, 7fa, 7fb, 7fc, 7fd, 7fe, 7ff, 7fg, 7fh, 7fi, 7fj, 7fk, 7fl, 7fm, 7fn, 7fo, 7fp, 7fq, 7fr, 7fs, 7ft, 7fu, 7fv, 7fw, 7fx, 7fy, 7fz, 7ga, 7gb, 7gc, 7gd, 7ge, 7gf, 7gg, 7gh, 7gi, 7gj, 7gk, 7gl, 7gm, 7gn, 7go, 7gp, 7gq, 7gr, 7gs, 7gt, 7gu, 7gv, 7gw, 7gx, 7gy, 7gz, 7ha, 7hb, 7hc, 7hd, 7he, 7hf, 7hg, 7hh, 7hi, 7hj, 7hk, 7hl, 7hm, 7hn, 7ho, 7hp, 7hq, 7hr, 7hs, 7ht, 7hu, 7hv, 7hw, 7hx, 7hy, 7hz, 7ia, 7ib, 7ic, 7id, 7ie, 7if, 7ig, 7ih, 7ii, 7ij, 7ik, 7il, 7im, 7in, 7io, 7ip, 7iq, 7ir, 7is, 7it, 7iu, 7iv, 7iw, 7ix, 7iy, 7iz, 7ja, 7jb, 7jc, 7jd, 7je, 7jf, 7jg, 7jh, 7ji, 7jj, 7jk, 7jl, 7jm, 7jn, 7jo, 7jp, 7jq, 7jr, 7js, 7jt, 7ju, 7jv, 7jw, 7jx, 7jy, 7jz, 7ka, 7kb, 7kc, 7kd, 7ke, 7kf, 7kg, 7kh, 7ki, 7kj, 7kl, 7km, 7kn, 7ko, 7kp, 7kq, 7kr, 7ks, 7kt, 7ku, 7kv, 7kw, 7kx, 7ky, 7kz, 7la, 7lb, 7lc, 7ld, 7le, 7lf, 7lg, 7lh, 7li, 7lj, 7lk, 7ll, 7lm, 7ln, 7lo, 7lp, 7lq, 7lr, 7ls, 7lt, 7lu, 7lv, 7lw, 7lx, 7ly, 7lz, 7ma, 7mb, 7mc, 7md, 7me, 7mf, 7mg, 7mh, 7mi, 7mj, 7mk, 7ml, 7mm, 7mn, 7mo, 7mp, 7mq, 7mr, 7ms, 7mt, 7mu, 7mv, 7mw, 7mx, 7my, 7mz, 7na, 7nb, 7nc, 7nd, 7ne, 7nf, 7ng, 7nh, 7ni, 7nj, 7nk, 7nl, 7nm, 7nn, 7no, 7np, 7nq, 7nr, 7ns, 7nt, 7nu, 7nv, 7nw, 7nx, 7ny, 7nz, 7oa, 7ob, 7oc, 7od, 7oe, 7of, 7og, 7oh, 7oi, 7oj, 7ok, 7ol, 7om, 7on, 7oo, 7op, 7oq, 7or, 7os, 7ot, 7ou, 7ov, 7ow, 7ox, 7oy, 7oz, 7pa, 7pb, 7pc, 7pd, 7pe, 7pf, 7pg, 7ph, 7pi, 7pj, 7pk, 7pl, 7pm, 7pn, 7po, 7pp, 7pq, 7pr, 7ps, 7pt, 7pu, 7pv, 7pw, 7px, 7py, 7pz, 7qa, 7qb, 7qc, 7qd, 7qe, 7qf, 7qg, 7qh, 7qi, 7qj, 7qk, 7ql, 7qm, 7qn, 7qo, 7qp, 7qq, 7qr, 7qs, 7qt, 7qu, 7qv, 7qw, 7qx, 7qy, 7qz, 7ra, 7rb, 7rc, 7rd, 7re, 7rf, 7rg, 7rh, 7ri, 7rj, 7rk, 7rl, 7rm, 7rn, 7ro, 7rp, 7rq, 7rr, 7rs, 7rt, 7ru, 7rv, 7rw, 7rx, 7ry, 7rz, 7sa, 7sb, 7sc, 7sd, 7se, 7sf, 7sg, 7sh, 7si, 7sj, 7sk, 7sl, 7sm, 7sn, 7so, 7sp, 7sq, 7sr, 7ss, 7st, 7su, 7sv, 7sw, 7sx, 7sy, 7sz, 7ta, 7tb, 7tc, 7td, 7te, 7tf, 7tg, 7th, 7ti, 7tj, 7tk, 7tl, 7tm, 7tn, 7to, 7tp, 7tq, 7tr, 7ts, 7tt, 7tu, 7tv, 7tw, 7tx, 7ty, 7tz, 7ua, 7ub, 7uc, 7ud, 7ue, 7uf, 7ug, 7uh, 7ui, 7uj, 7uk, 7ul, 7um, 7un, 7uo, 7up, 7uq, 7ur, 7us, 7ut, 7uu, 7uv, 7uw, 7ux, 7uy, 7uz, 7va, 7vb, 7vc, 7vd, 7ve, 7vf, 7vg, 7vh, 7vi, 7vj, 7vk, 7vl, 7vm, 7vn, 7vo, 7vp, 7vq, 7vr, 7vs, 7vt, 7vu, 7vv, 7vw, 7vx, 7vy, 7vz, 7wa, 7wb, 7wc, 7wd, 7we, 7wf, 7wg, 7wh, 7wi, 7wj, 7wk, 7wl, 7wm, 7wn, 7wo, 7wp, 7wq, 7wr, 7ws, 7wt, 7wu, 7wv, 7ww, 7wx, 7wy, 7wz, 7xa, 7xb, 7xc, 7xd, 7xe, 7xf, 7xg, 7xh, 7xi, 7xj, 7xk, 7xl, 7xm, 7xn, 7xo, 7xp, 7xq, 7xr, 7xs, 7xt, 7xu, 7xv, 7xw, 7xx, 7xy, 7xz, 7ya, 7yb, 7yc, 7yd, 7ye, 7yf, 7yg, 7yh, 7yi, 7yj, 7yk, 7yl, 7ym, 7yn, 7yo, 7yp, 7yq, 7yr, 7ys, 7yt, 7yu, 7yv, 7yw, 7yx, 7yy, 7yz, 7za, 7zb, 7zc, 7zd, 7ze, 7zf, 7zg, 7zh, 7zi, 7zj, 7zk, 7zl, 7zm, 7zn, 7zo, 7zp, 7zq, 7zr, 7zs, 7zt, 7zu, 7zv, 7zw, 7zx, 7zy, 7zz, 7aa, 7ab, 7ac, 7ad, 7ae, 7af, 7ag, 7ah, 7ai, 7aj, 7ak, 7al, 7am, 7an, 7ao, 7ap, 7aq, 7ar, 7as, 7at, 7au, 7av, 7aw, 7ax, 7ay, 7az, 7ba, 7bb, 7bc, 7bd, 7be, 7bf, 7bg, 7bh, 7bi, 7bj, 7bk, 7bl, 7bm, 7bn, 7bo, 7bp, 7bq, 7br, 7bs, 7bt, 7bu, 7bv, 7bw, 7bx, 7by, 7bz, 7ca, 7cb, 7cc, 7cd, 7ce, 7cf, 7cg, 7ch, 7ci, 7cj, 7ck, 7cl, 7cm, 7cn, 7co, 7cp, 7cq, 7cr, 7cs, 7ct, 7cu, 7cv, 7cw, 7cx, 7cy, 7cz, 7da, 7db, 7dc, 7dd, 7de, 7df, 7dg, 7dh, 7di, 7dj, 7dk, 7dl, 7dm, 7dn, 7do, 7dp, 7dq, 7dr, 7ds, 7dt, 7du, 7dv, 7dw, 7dx, 7dy, 7dz, 7ea, 7eb, 7ec, 7ed, 7ee, 7ef, 7eg, 7eh, 7ei, 7ej, 7ek, 7el, 7em, 7en, 7eo, 7ep, 7eq, 7er, 7es, 7et, 7eu, 7ev, 7ew, 7ex, 7ey, 7ez, 7fa, 7fb, 7fc, 7fd, 7fe, 7ff, 7fg, 7fh, 7fi, 7fj, 7fk, 7fl, 7fm, 7fn, 7fo, 7fp, 7fq, 7fr, 7fs, 7ft, 7fu, 7fv, 7fw, 7fx, 7fy, 7fz, 7ga, 7gb, 7gc, 7gd, 7ge, 7gf, 7gg, 7gh, 7gi, 7gj, 7gk, 7gl, 7gm, 7gn, 7go, 7gp, 7gq, 7gr, 7gs, 7gt, 7gu, 7gv, 7gw, 7gx, 7gy, 7gz, 7ha, 7hb, 7hc, 7hd, 7he, 7hf, 7hg, 7hh, 7hi, 7hj, 7hk, 7hl, 7hm, 7hn, 7ho, 7hp, 7hq, 7hr, 7hs, 7ht, 7hu, 7hv, 7hw, 7hx, 7hy, 7hz, 7ia, 7ib, 7ic, 7id, 7ie, 7if, 7ig, 7ih, 7ii, 7ij, 7ik, 7il, 7im, 7in, 7io, 7ip, 7iq, 7ir, 7is, 7it, 7iu, 7iv, 7iw, 7ix, 7iy, 7iz, 7ja, 7jb, 7jc, 7jd, 7je, 7jf, 7jg, 7jh, 7ji, 7jj, 7jk, 7jl, 7jm, 7jn, 7jo, 7jp, 7jq, 7jr, 7js, 7jt, 7ju, 7jv, 7jw, 7jx, 7jy, 7jz, 7ka, 7kb, 7kc, 7kd, 7ke, 7kf, 7kg, 7kh, 7ki, 7kj, 7kl, 7km, 7kn, 7ko, 7kp, 7kq, 7kr, 7ks, 7kt, 7ku, 7kv, 7kw, 7kx, 7ky, 7kz, 7la, 7lb, 7lc, 7ld, 7le, 7lf, 7lg, 7lh, 7li, 7lj, 7lk, 7ll, 7lm, 7ln, 7lo, 7lp, 7lq, 7lr, 7ls, 7lt, 7lu, 7lv, 7lw, 7lx, 7ly, 7lz, 7ma, 7mb, 7mc, 7md, 7me, 7mf, 7mg, 7mh, 7mi, 7mj, 7mk, 7ml, 7mm, 7mn, 7mo, 7mp, 7mq, 7mr, 7ms, 7mt, 7mu, 7mv, 7mw, 7mx, 7my, 7mz, 7na, 7nb, 7nc, 7nd, 7ne, 7nf, 7ng, 7nh, 7ni, 7nj, 7nk, 7nl, 7nm, 7nn, 7no, 7np, 7nq, 7nr, 7ns, 7nt, 7nu, 7nv, 7nw, 7nx, 7ny, 7nz, 7oa, 7ob, 7oc, 7od, 7oe, 7of, 7og, 7oh, 7oi, 7oj, 7ok, 7ol, 7om, 7on, 7oo, 7op, 7oq, 7or, 7os, 7ot, 7ou, 7ov, 7ow, 7ox, 7oy, 7oz, 7pa, 7pb, 7pc, 7pd, 7pe, 7pf, 7pg, 7ph, 7pi, 7pj, 7pk, 7pl, 7pm, 7pn, 7po, 7pp, 7pq, 7pr, 7ps, 7pt, 7pu, 7pv, 7pw, 7px, 7py, 7pz, 7qa, 7qb, 7qc, 7qd, 7qe, 7qf, 7qg, 7qh, 7qi, 7qj, 7qk, 7ql, 7qm, 7qn, 7qo, 7qp, 7qq, 7qr, 7qs, 7qt, 7qu, 7qv, 7qw, 7qx, 7qy, 7qz, 7ra, 7rb, 7rc, 7rd, 7re, 7rf, 7rg, 7rh, 7ri, 7rj, 7rk, 7rl, 7rm, 7rn, 7ro, 7rp, 7rq, 7rr, 7rs, 7rt, 7ru, 7rv, 7rw, 7rx, 7ry, 7rz, 7sa, 7sb, 7sc, 7sd, 7se, 7sf, 7sg, 7sh, 7si, 7sj, 7sk, 7sl, 7sm, 7sn, 7so, 7sp, 7sq, 7sr, 7ss, 7st, 7su, 7sv, 7sw, 7sx, 7sy, 7sz, 7ta, 7tb, 7tc, 7td, 7te, 7tf, 7tg, 7th, 7ti, 7tj, 7tk, 7tl, 7tm, 7tn, 7to, 7tp, 7tq, 7tr, 7ts, 7tt, 7tu, 7tv, 7tw, 7tx, 7ty, 7tz, 7ua, 7ub, 7uc, 7ud, 7ue, 7uf, 7ug, 7uh, 7ui, 7uj, 7uk, 7ul, 7um, 7un, 7uo, 7up, 7uq, 7ur, 7us, 7ut, 7uu, 7uv, 7uw, 7ux, 7uy, 7uz, 7va, 7vb, 7vc, 7vd, 7ve, 7vf, 7vg, 7vh, 7vi, 7vj, 7vk, 7vl, 7vm, 7vn, 7vo, 7vp, 7vq, 7vr, 7vs, 7vt, 7vu, 7vv, 7vw, 7vx, 7vy, 7vz, 7wa, 7wb, 7wc, 7wd, 7we, 7wf, 7wg, 7wh, 7wi, 7wj, 7wk, 7wl, 7wm, 7wn, 7wo, 7wp, 7wq, 7wr, 7ws, 7wt, 7wu, 7wv, 7ww, 7wx, 7wy, 7wz, 7xa, 7xb, 7xc, 7xd, 7xe, 7xf, 7xg, 7xh, 7xi, 7xj, 7xk, 7xl, 7xm, 7xn, 7xo, 7xp, 7xq, 7xr, 7xs, 7xt, 7xu, 7xv, 7xw, 7xx, 7xy, 7xz, 7ya, 7yb, 7yc, 7yd, 7ye, 7yf, 7yg, 7yh, 7yi, 7yj, 7yk, 7yl, 7ym, 7yn, 7yo, 7yp, 7yq, 7yr, 7ys, 7yt, 7yu, 7yv, 7yw, 7yx, 7yy, 7yz, 7za, 7zb, 7zc, 7zd, 7ze, 7zf, 7zg, 7zh, 7zi, 7zj, 7zk, 7zl, 7zm, 7zn, 7zo, 7zp, 7zq, 7zr, 7zs, 7zt, 7zu, 7zv, 7zw, 7zx, 7zy, 7zz

1 DECEASED-NAME (Type or Print)		Middle		Last		2a DATE KNOWN OF EST- DEATH MATED		Month	Day	Year	2b HOUR
George Robert Barnes						3-11-68		19	7	20pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	3-7-1942	26 YRS					Month	Day	Year	
7a BIRTH-PLACE (State or foregn country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Kentucky		USA				Prince George's		Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George Hospital									
13a USUAL RESIDENCE (Where deceased lived, if instator on Residence before admission), STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Prince George		Oxon Hill		YES <input type="checkbox"/> NO <input type="checkbox"/>		5674 Alice Ave., Apt. 101			
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last		
Raymond L. Barnes, Sr.					Geneva Harpe						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest											
7220 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
119.0											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR:MIN 7:01 P.M. 3-11-19 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		Shot self while cleaning gun.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home farm, street, factory, office building, etc.) home		21f LOCATION Street or RFD No		City or Town		County		State	
				same as # 13							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe MD		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3-12-68			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		3/15/68		Cedar Hill Cemetery		Suitland, Maryland					
24 FUNERAL DIRECTOR		Demaine Funeral Homes, Alexandria, Va.		25a REC'D BY REG STRAR DATE		25b REGISTRAR'S SIGNATURE					
				MAR 18 1968							

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M.D. 4515										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF DEATH			2b. HOUR								
James H. Barnes												3-2-68			19 1:40am								
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR								
Male		Negro		5-24-1944		23 YRS		MONTHS		DAYS		3 Month 2 Day Year 68			2:17am								
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH				Md.							
Washington DC USA				DC USA								Prince George's											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly				Prince George Hospital																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER							
New York				New York City				Bronx				YES <input type="checkbox"/> NO <input type="checkbox"/>				1157 Jackson Avenue							
14 FATHER'S NAME			First			Middle			Last			15 MOTHER'S MAIDEN NAME			First			Middle			Last		
Hardy			Barnes																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS											
Yes				074 348 987				U. S. Army Records															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock																							
DUE TO, OR AS A CONSEQUENCE OF Laceration of neck																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause																							
DUE TO, OR AS A CONSEQUENCE OF																							
DUE TO, OR AS A CONSEQUENCE OF																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
				1:40am 3-2-19 68				Driver of car which struck bridge abutment															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office, bus, dog, etc.)				21f. LOCATION Street or RFD No				City or Town				County				State			
				Baltimore Parkway at Rt. 193 overpass., Prince George Co., Md.																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				22b. DATE SIGNED															
John Kehoe MD				Riverdale, Md.				3-3-68															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)				(County)				(State)			
Burial				March 7 ' 68				Long Island National				Farmingdale				New York							
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. YEARS SIGNATURE															
Fun. Home Harry Witzke				12 1968				John Kehoe															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Flora M BEACH</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>68</b>			2b. HOUR <b>6A</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>3/11/1874</b>		6. AGE (In years last birthday) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M.H.		
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md				
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RESIDENT MGR.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>APT. HOUSE</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>D.C.</b>			13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Wash.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1954 GE Rd NW.</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>J</b> Last <b>HUTCHINSON</b>			15. MOTHER'S MAIDEN NAME First <b>AMELIA</b> Middle <b>SHELTON</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>HYATTSVILLE N.H. Records.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <b>4/2/68</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (At home farm street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> , 19 <b>64</b> , to <b>Mar 2</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Feb 21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Vin Ferguson</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Mar 2 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>TILL BERGEMANN</b>			22e. ADDRESS <b>Greenbelt Md (Baltimore)</b> <b>Greenbelt Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>MAR 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>WASH. D.C.</b>			
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>			ADDRESS <b>4400 Chapin St NW Wash. D.C.</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>Jeanette BEALE</b>		First Middle Last		2a. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1968</b>		2b. HOUR <b>M</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>2-8-1903</b>		6. AGE (in years lost birthday) <b>65</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md	
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greenbelt Convalescent Ctr</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>31222 Evers Trail</b>		14. FATHER'S NAME First <b>JOHN</b> Middle <b>Crawford</b> Last <b>Crawford</b>		15. MOTHER'S MAIDEN NAME First <b>LILLY</b> Middle <b>Fairchild</b> Last <b>Fairchild</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT <b>RICHARD A BEALE GROVLAND</b> Address <b>RD GENESE NY</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic carcinoma of lung.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of endometrium.</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 months</b> <b>1 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10 January 1968</b> to <b>23 March 1968</b> , that (I) (we) last saw the deceased alive on <b>7 March 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Samuel T. Kimball</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>T. KIMBALL</b>				22e. ADDRESS <b>9801 Georgia Avenue, Silver Spring Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/27/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PACIFIC VIEW MEMORIAL</b>		23d. LOCATION (City or Town) (County) (State) <b>NEWBOLT BEACH CALIF.</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS</b> ADDRESS <b>1800 Chapin St NW Wash. D.C.</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
James		Bernard	Beall Jr.	March	23 <sup>rd</sup>	Day	1968	1:55p M
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)	7. UNDER 1 YEAR		7. UNDER 24 HRS.
Male	White		Nov 4, 1915		62 YRS.	MONTHS	DAYS	HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				Prince George Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George General		Self-employed		retail		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md		Pr. Geo.		New Carrollton				6007 84th Avenue
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
James B. Beall Sr.				Mildred Ritchie				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
no		720-16-6958		Catherine H. Beall		see # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 410.4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from June 1965 to Mar 22 1968, that (I) (we) last saw the deceased alive on Mar 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>William D. Rosson</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>3/23/68</u>		
22d. PHYSICIAN'S NAME (Type) William D. Rosson MD						22e. ADDRESS 5701 85th Av., Hyattsville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3/26/68		Ft. Lincoln		Bladensburg, Maryland		
24. FUNERAL DIRECTOR Jos. Gawler's Sons				ADDRESS 5130 Wisconsin Av., Wash. D.C.		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
						MAR 27 1968		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04519

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>BEULAH</b>		First <b>E.</b>	Middle	Last <b>BEARD</b>	2a. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1968</b>		2b. HOUR <b>1:50 P. M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 17-1880</b>		6. AGE (In years last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Pr. George's</b> Md.		
10. CITY OR TOWN OF DEATH <b>College Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5205- Palco Place</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5205- Palco Place</b>
14. FATHER'S NAME First <b>Daive</b> Middle <b>H.</b> Last <b>East</b>		15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>McCray</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Louis B. Clark</b> Address <b>-5014- 26th. Ave., SE</b> Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Stomach Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Three</b> <b>3-4 hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4301</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> , 19 <b>68</b> , to <b>3/27</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Thomas F. Cullen</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/27/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Thomas F. Cullen</b>				22e. ADDRESS <b>5103- Marlboro Pike, Hillside, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Providence Presbyterian Cem. Raphine, Va.</b>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <b>Simmons Bros. 1661-Gd. Hope Rd. SE. DC</b>				ADDRESS <b>Wash</b>		25a. REC'D BY REGISTRAR <b>APR 1 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

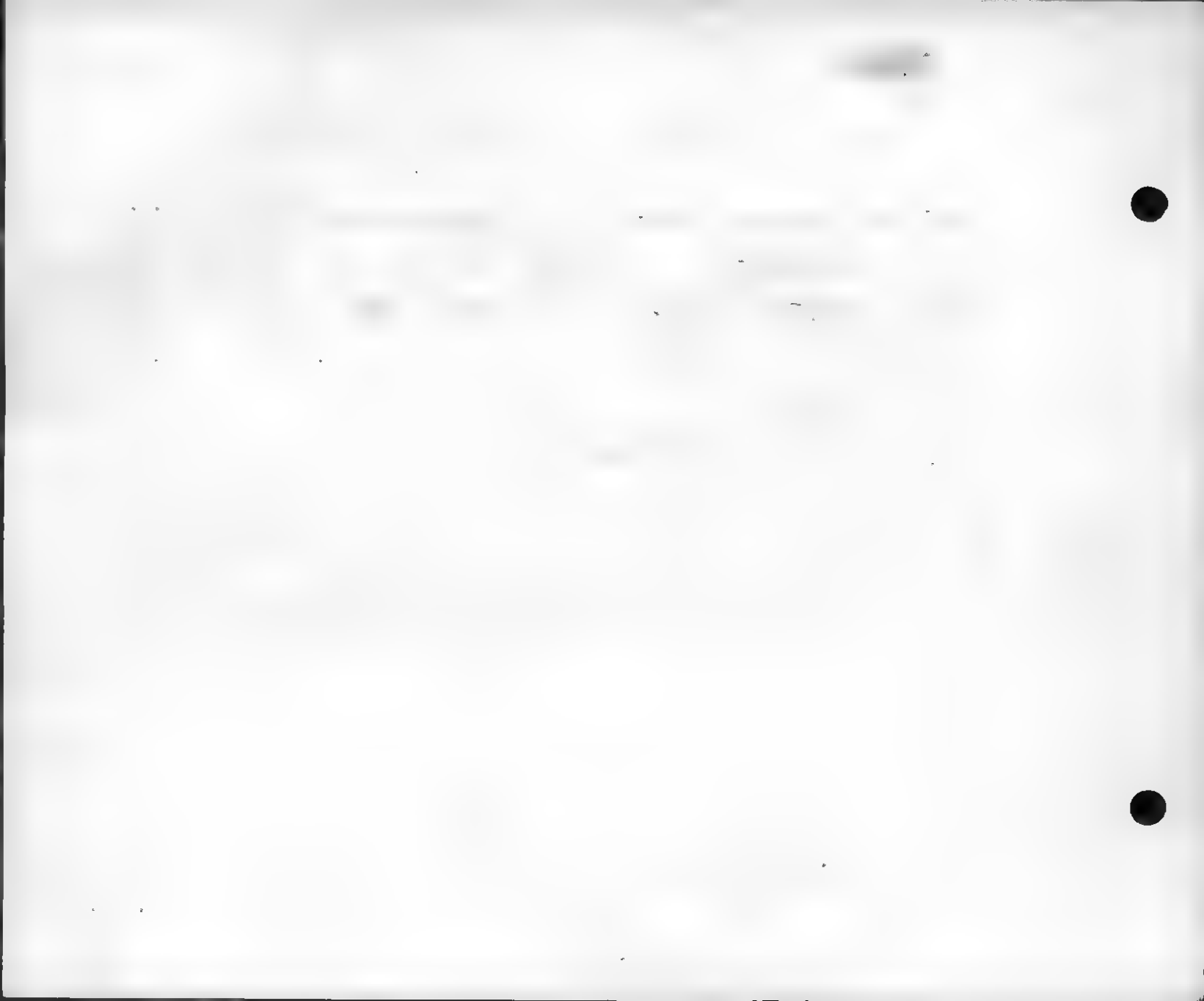
CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>		d. STREET ADDRESS <u>3145 Beech Street, N.W.</u> <u>6500 Rogers Road</u>	
3 NAME OF DECEASED (Type or print) <u>HENRIETTA Sophie</u>		4 DATE OF DEATH Month <u>MARCH</u> Day <u>6</u> Year <u>1968</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>81</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>George L. Brandt</u>		14. MOTHER'S MAIDEN NAME <u>Marie Heinemann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>579-60-0920</u>	
17. INFORMANT <u>Mrs. Valerie B. Rohland- See Item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>Acute Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <u>at Death</u> <u>precipitated immediately</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 196 <u>8</u> , to <u>March 6</u> , 196 <u>8</u> , that (I) (we) last saw the deceased alive on <u>March 4</u> , 196 <u>8</u> , and that death occurred at <u>7:55 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>3-6-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Stuart L. Nelson</u>		22d. ADDRESS <u>831 University Blvd East Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-9-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

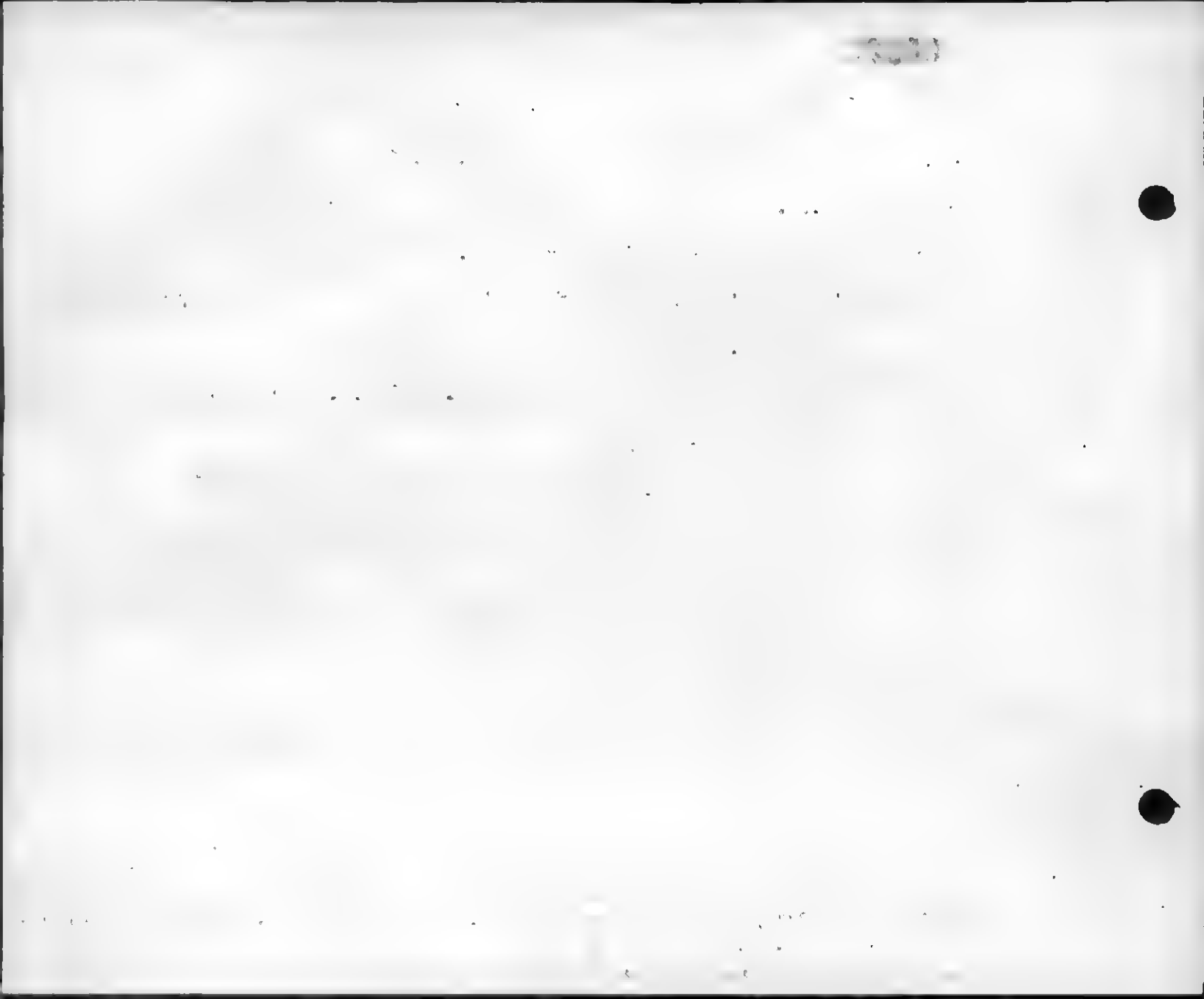
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MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>KAREN</b> First <b>SUE</b> Middle <b>BELLO</b> Last		2a. DATE OF DEATH <b>MARCH</b> Month <b>14</b> Day <b>1968</b> Year		2b. HOUR <b>6 A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOV. 12, 1948</b>	
6. AGE (In years last birthday) <b>19</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Prince Georges</b>		Md			
10. CITY OR TOWN OF DEATH <b>District Heights</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3116 Wintergreen Ave.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince Georges</b>		13b. CITY OR TOWN <b>District Heights</b>		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13d. STREET AND NUMBER <b>3116 Wintergreen Avenue</b>					
14. FATHER'S NAME First <b>Charles H.</b> Middle <b>Echterling</b> Last			15. MOTHER'S MAIDEN NAME First <b>Betty</b> Middle <b>Filling</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>0</b>		17. INFORMANT <b>John J. Bello Jr.</b> Address <b>Same As # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary</b> <b>1759</b> DUE TO, OR AS A CONSEQUENCE OF <b>Overweight, Coronary, High Blood</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1759</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1967</b> to <b>Feb. 14, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb. 14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Bentamin S. Pearson</b> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) <b>BENTAMIN S. PEARSON</b>					22e. ADDRESS <b>6166 Old Belts Rd. Ros</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Clinton, Prince Georges, Md.</b>					
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 21 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

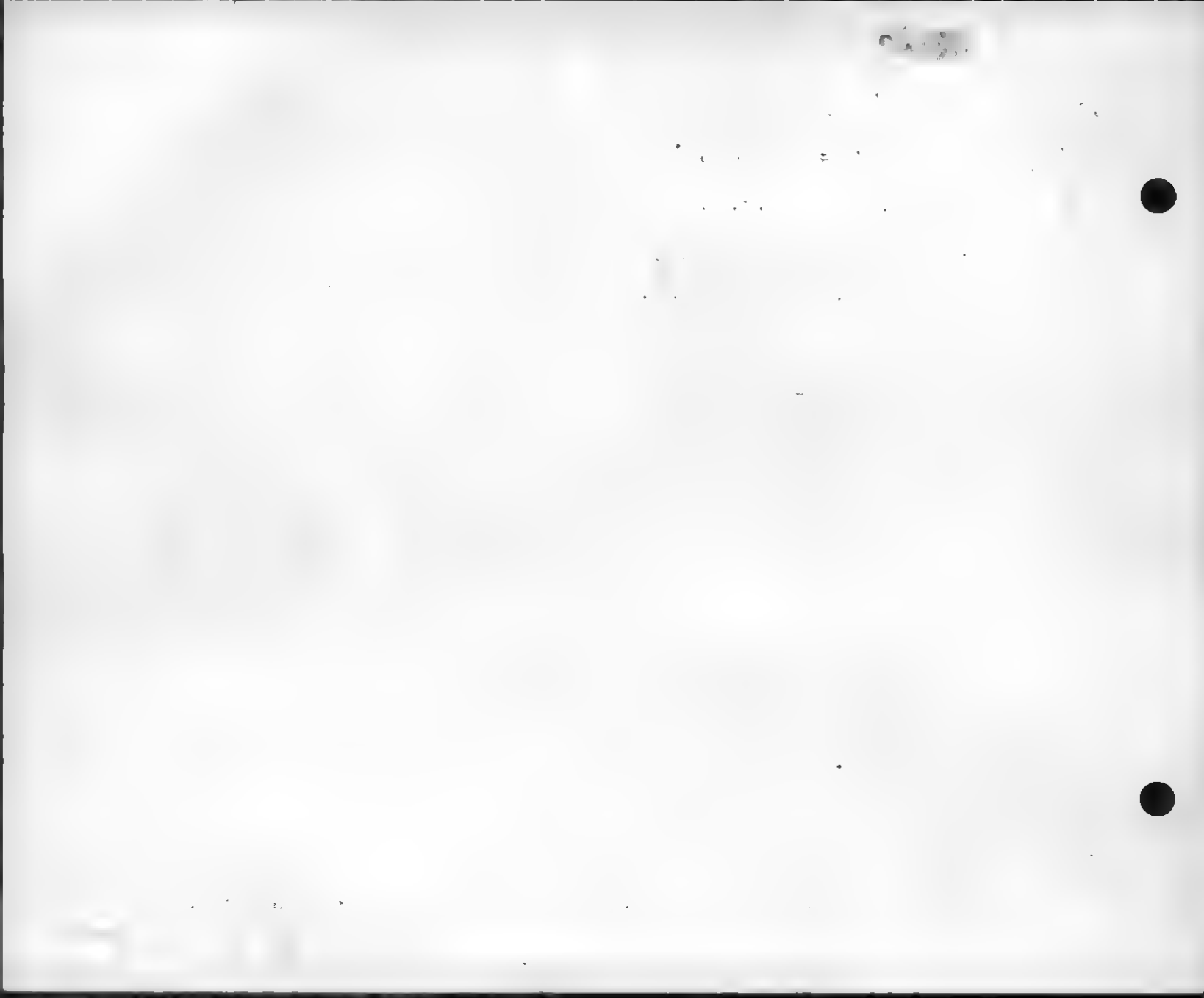


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

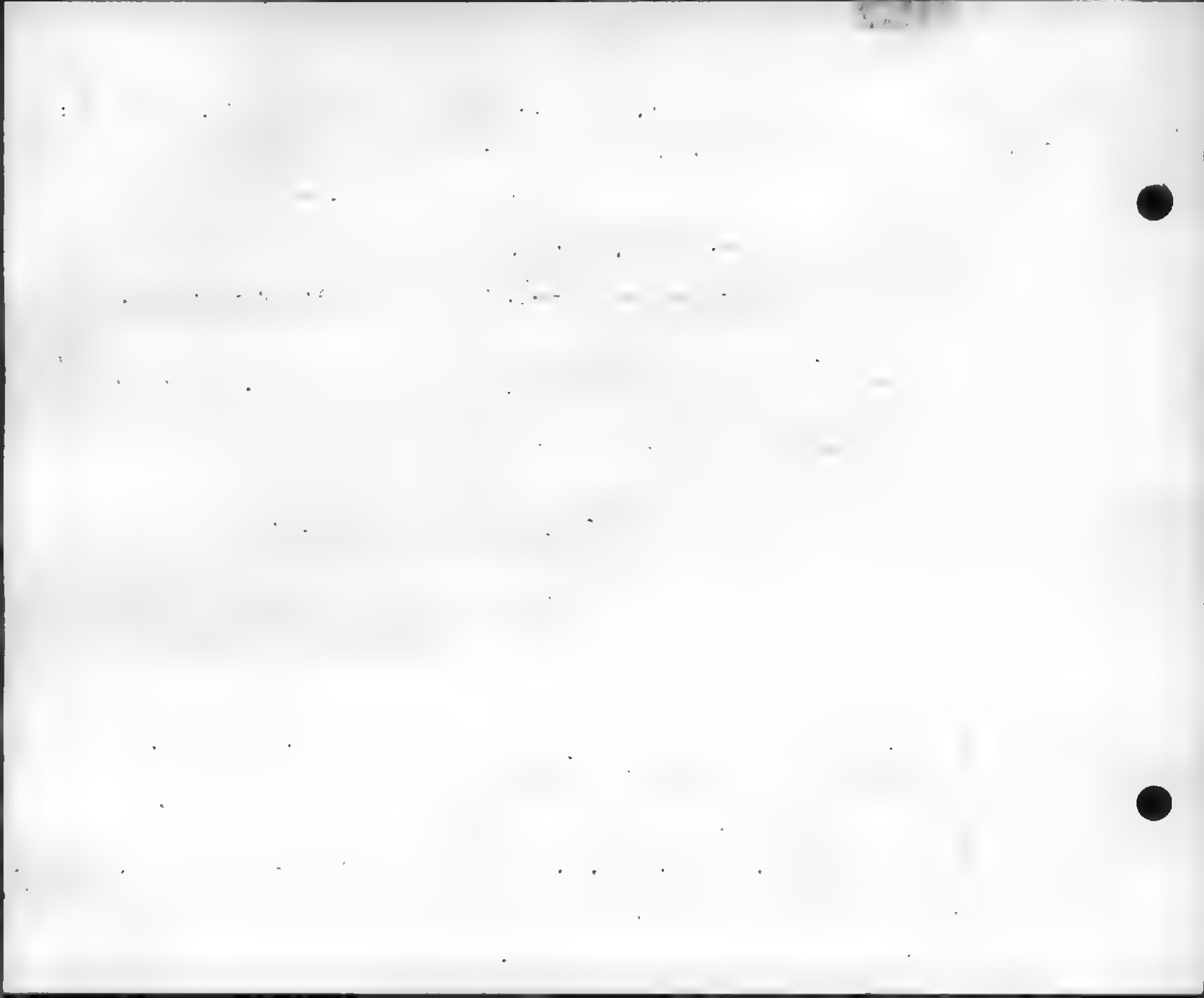
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <b>FELIX</b>		First		Middle		Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 29 1968		2b HOUR AM	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Aug. 8, 1907</b>		6 AGE (In years less birthday) <b>60</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month <b>March</b> Day <b>29</b> Year <b>1968</b>	
7a BIRTHPLACE (State or foreign country) <b>Penn.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Painter</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hospital Prince George General</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Painter</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Building</b>		13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>P. G.</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>P. G.</b>		13c CITY OR TOWN <b>Hyattsville</b>		3d INS DE CITY, MTS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>5235 Kennilworth Avenue</b>			
14. FATHER'S NAME First Middle Last <b>John Benn</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Cecelia Teck</b>				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>1921-1925</b>			
16b SOCIAL SECURITY NO <b>1921-1925</b>				17 INFORMANT <b>Pearl Benn Same as #13 (wife)</b>				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109 Coronary thrombosis few min</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary arteriosclerosis 1 yr</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dayton O. Watkins</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <b>3-29-68</b>			
EXAMINER'S NAME (Type) <b>DAYTON O. WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town or county)							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE <b>4/1/68</b>				23c NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>			
23d LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>				24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a REC'D BY REGISTRAR DATE <b>APR 1 - 1968</b>			
				25b REGISTRAR'S SIGNATURE <b>Francis Gasch</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 1968										MAY 1968														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
Items 6, 7a & 7b Film G399 3/28/68										CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)					First Middle Last					2a DATE OF DEATH Month Day Year					2b. HOUR A M									
Saul					F. Berman					March 20, 1968					10:45 A									
3 SEX Male					4 RACE Caucasian					5 DATE OF BIRTH 3/12/89					6 AGE (In years last birthday) 78 79 YRS.									
7a BIRTHPLACE (State or foreign country) New York					7b CITIZEN OF WHAT COUNTRY? USA					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 COUNTY OF DEATH Prince Georges Md									
10. CITY OR TOWN OF DEATH Cheverly					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland					13b CITY OR TOWN Prince Georges					13c CITY OR TOWN Greenbelt					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>									
13e STREET AND NUMBER 9294 Edmonston Rd.					14 FATHER'S NAME First Middle Last Abraham Berman					15 MOTHER'S MAIDEN NAME First Middle Last Anna Oliberg														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) No					16b SOCIAL SECURITY NO. 114-12-5781					17 INFORMANT Avron Berman (son)					Address 2747 N. Yucatan St Arlington, Va.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>																								
410.7 DUE TO, OR AS A CONSEQUENCE OF <u>Acute Myocardial Infarction.</u>																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u>																								
(c) <u>Chronic Heart Disease</u>																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																								
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC					21f LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from <u>March 5, 1968</u> , to <u>March 20, 1968</u> , that (X) (we) last saw the deceased alive on <u>March 20, 1968</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>Hernandez</u>										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 3/20/68									
22d PHYSICIAN'S NAME (Type) Tomas J. Hernandez, M. D.										22e. ADDRESS Prince Georges General Hospital, Cheverly.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE March 22, 1968					23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden					23d. LOCATION (City or Town) (County) Maryland Falls Church, Virginia									
24. FUNERAL DIRECTOR Donald M. Stein										ADDRESS 232 Carroll St., N.W. Wash., D.C.					25a REC'D BY REGISTRAR MAR 26 1968					25b REGISTRAR'S SIGNATURE <u>John's Judge</u>				



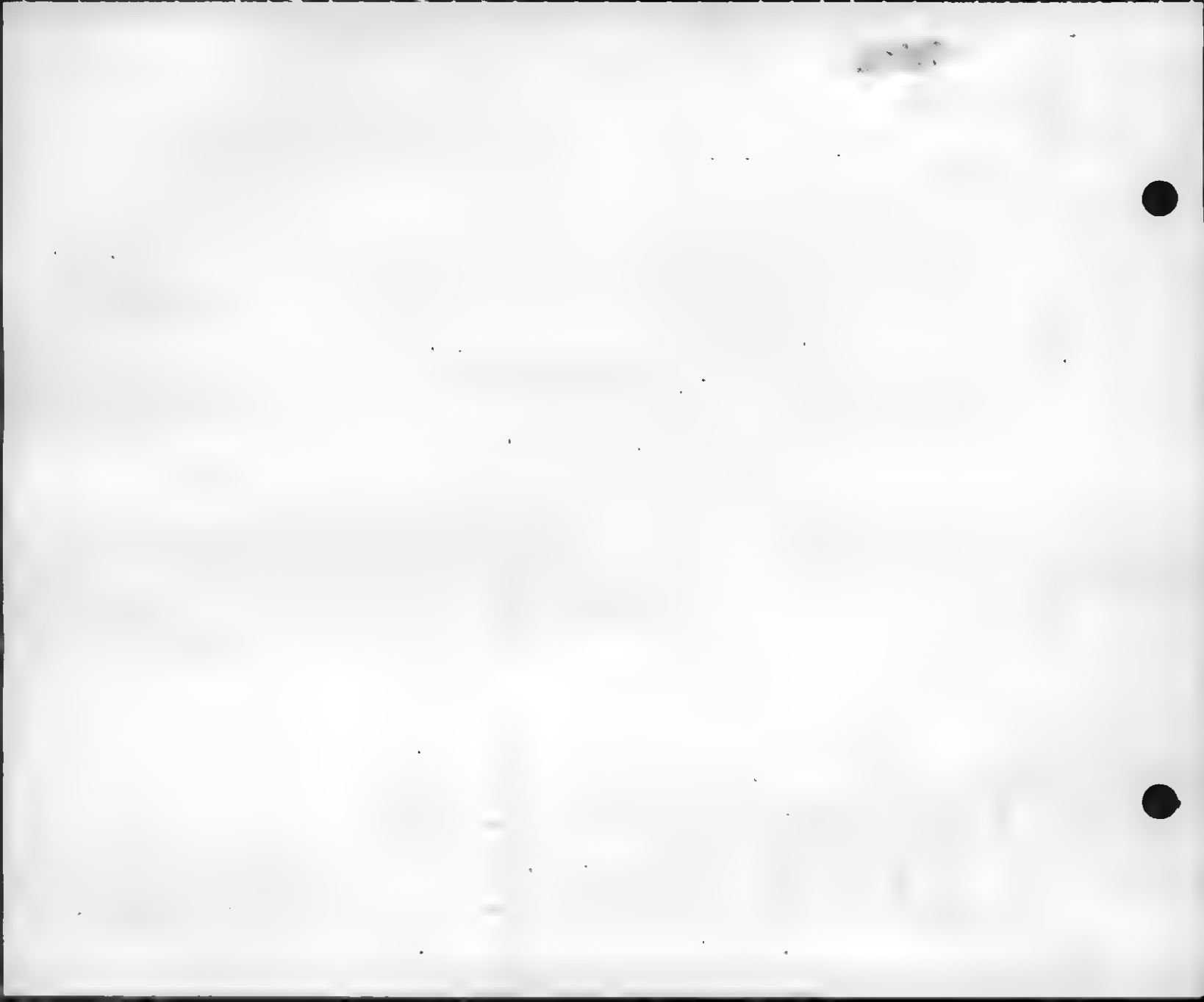
# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last James Austin Billings			2a. DATE KNOWN OF DEATH Month Day Year 3-16-68			2b. HOUR un known		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12-16-1924	6. AGE (in years last birthday) 43 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 3 20 68 1:00pm		
7a. BIRTHPLACE (State or foreign country) Washington D C		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Seabrook		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 9300 Vaughn Place			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automobile	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY - HITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9300 Vaughn Place
14. FATHER'S NAME First Middle Last George Billings			15. MOTHER'S MAIDEN NAME First Middle Last Harriet Parker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 1942-1945 578 22 0598		17. INFORMANT Genevieve L. Billings			ADDRESS Seabrook, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>3-16-68</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. unknown 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) unknown				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) unknown		21f. LOCATION Street or R.F.D. No City or Town County State unknown				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-21-68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>		





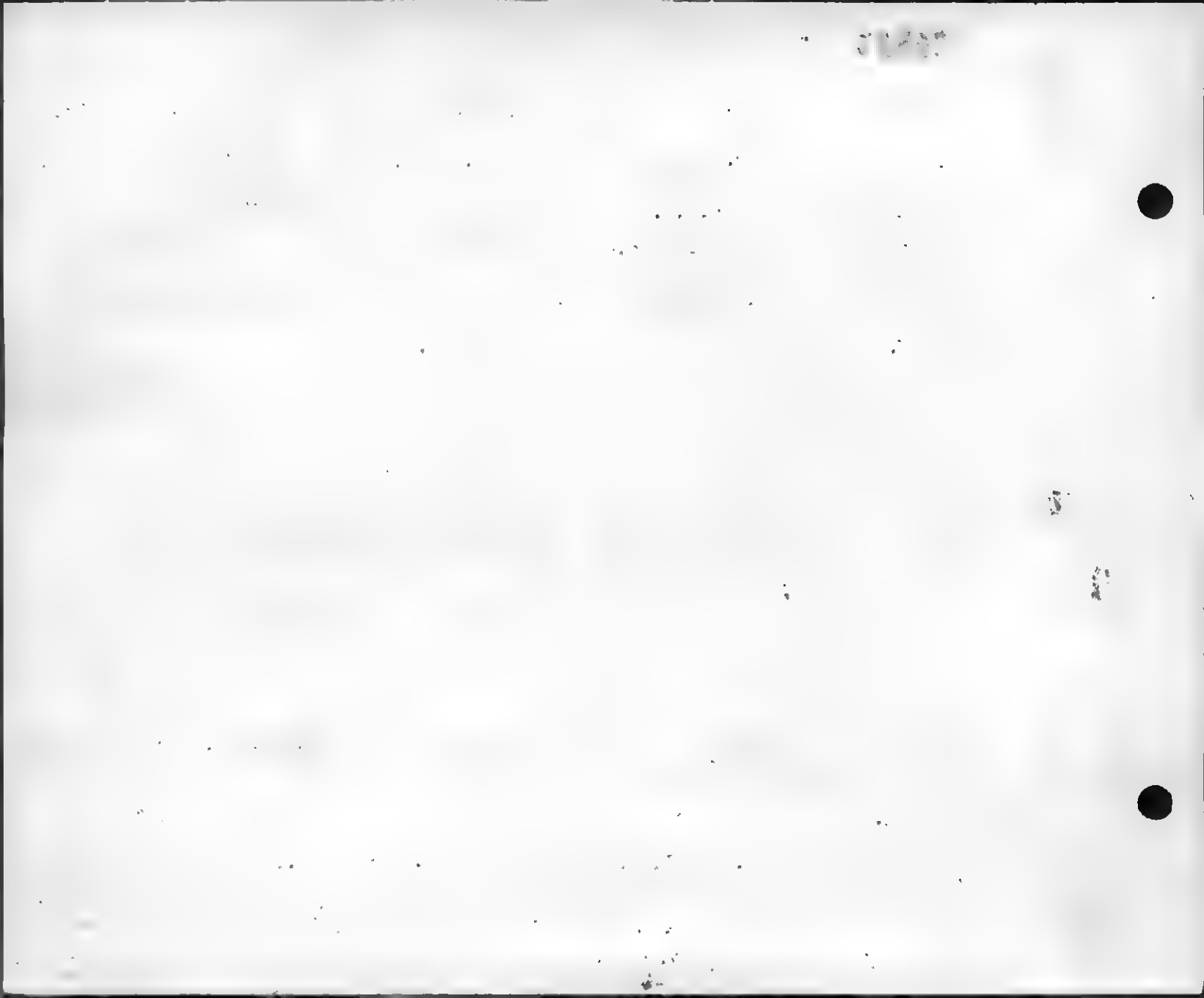
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

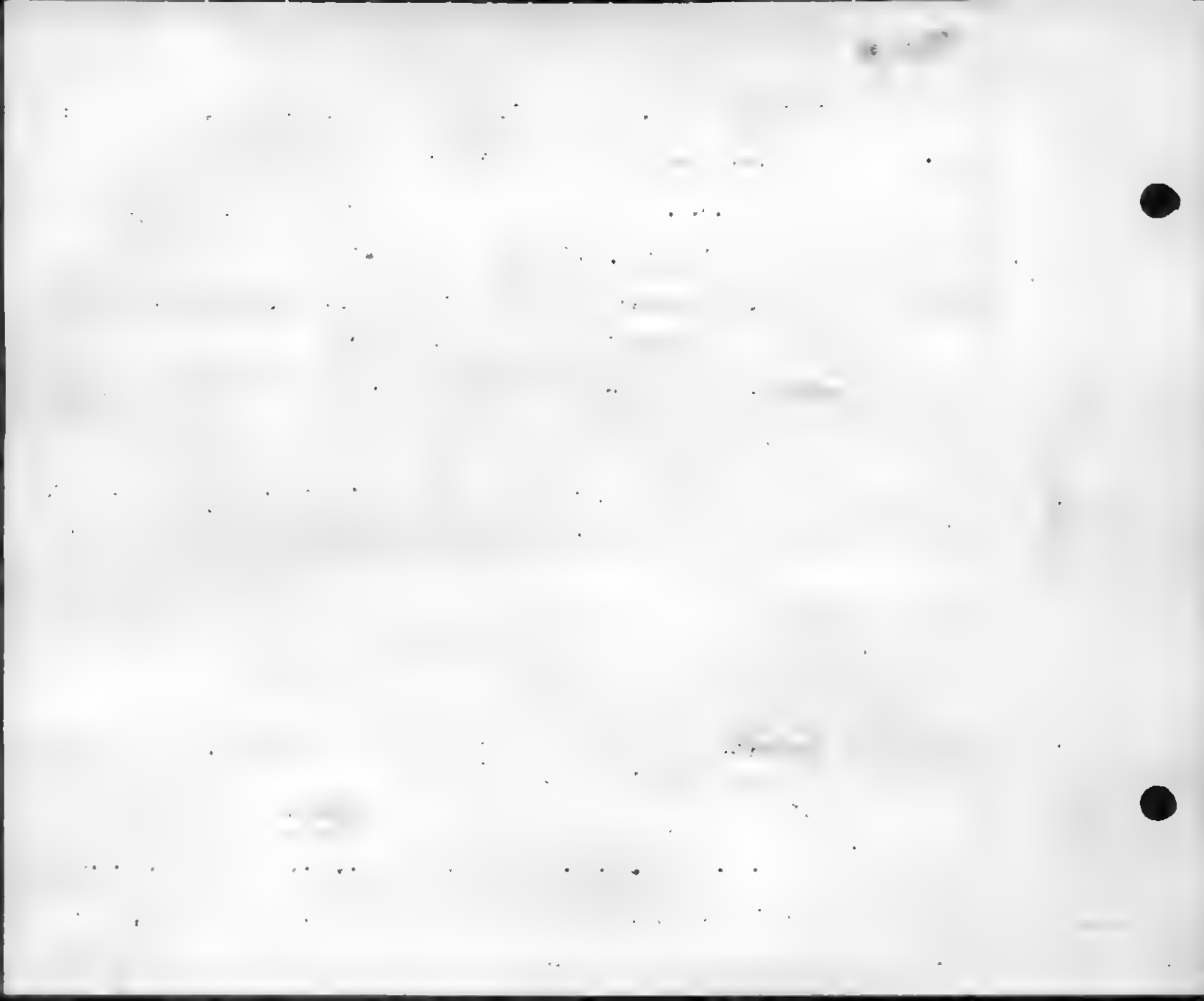
1. DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-between;"><span>First</span><span>Middle</span><span>Last</span></div> <div style="display: flex; justify-content: space-between;"><span>Baby</span><span>Boy</span><span>Bokoles</span></div>			2a. DATE OF DEATH Month Day Year March 28, 1968		2b. HOUR 9:30AM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH March 28, 1968		6. AGE (In years last birthday) YRS. MONTHS DAYS 40	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH prince Georges Md			
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) prince Geo. Gen'l Hospital		12a. JSJAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY prince Georges	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12406 Rustic Hill Drive		
14. FATHER'S NAME First Middle Last John M. Bokoles			15. MOTHER'S MAIDEN NAME First Middle Last Judith A. Bee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity</u> 777X DUE TO, OR AS A CONSEQUENCE OF (b) <u>pre maturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from March 28, 1968, to March 28, 1968, that (I) <del>(we)</del> last saw the deceased alive on March 28, 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.						
22b. SIGNATURE <u>James E. Abell</u>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-28-68		
22d. PHYSICIAN'S NAME (Type) James E. Abell, M. D.			22e. ADDRESS 6001 Landover Rd., Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4/13/68	23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hosp		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland		
24. FUNERAL DIRECTOR <u>HARRY W. PENN, JR.</u> ADMINISTRATOR		25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR 9:30 P M	
			Benjamin		M.		Bolinger		March 6, 1968				
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS	
Male			Caucasian			11/2/08			59 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Md			U.S.A.						Prince Georges			Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince Geo. Gen'l Hospital			Pharmacological			Irm				
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Prince Georges			University Pk						6413 Adelphi Road	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MA DEN NAME			First Middle Last	
			Benjamin W				Bolinger					Betty Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address				
no			212 01 7988			Pauline H Bolinger			University park, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>anuria</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic cancer forelsperitoned</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Primary cancer of lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 months</u> <u>3 yrs</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <u>physician</u> attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>March 6</u> , 19 <u>68</u> , that (I) <u>yes</u> last saw the deceased alive on <u>March 6</u> , 19 <u>68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>yes</u> (did) <u>not</u> view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
			March 6, 1968										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
John H. E. Bayly, M. D.			1835 Eye St., NW., Washington, D.C. 20006										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			March 9, 1968			Prospect Hill Cemetery			Washington D. C.				
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons			Hyattsville, Md.			DATE MAR 11 1968			Charles J. [Signature]				

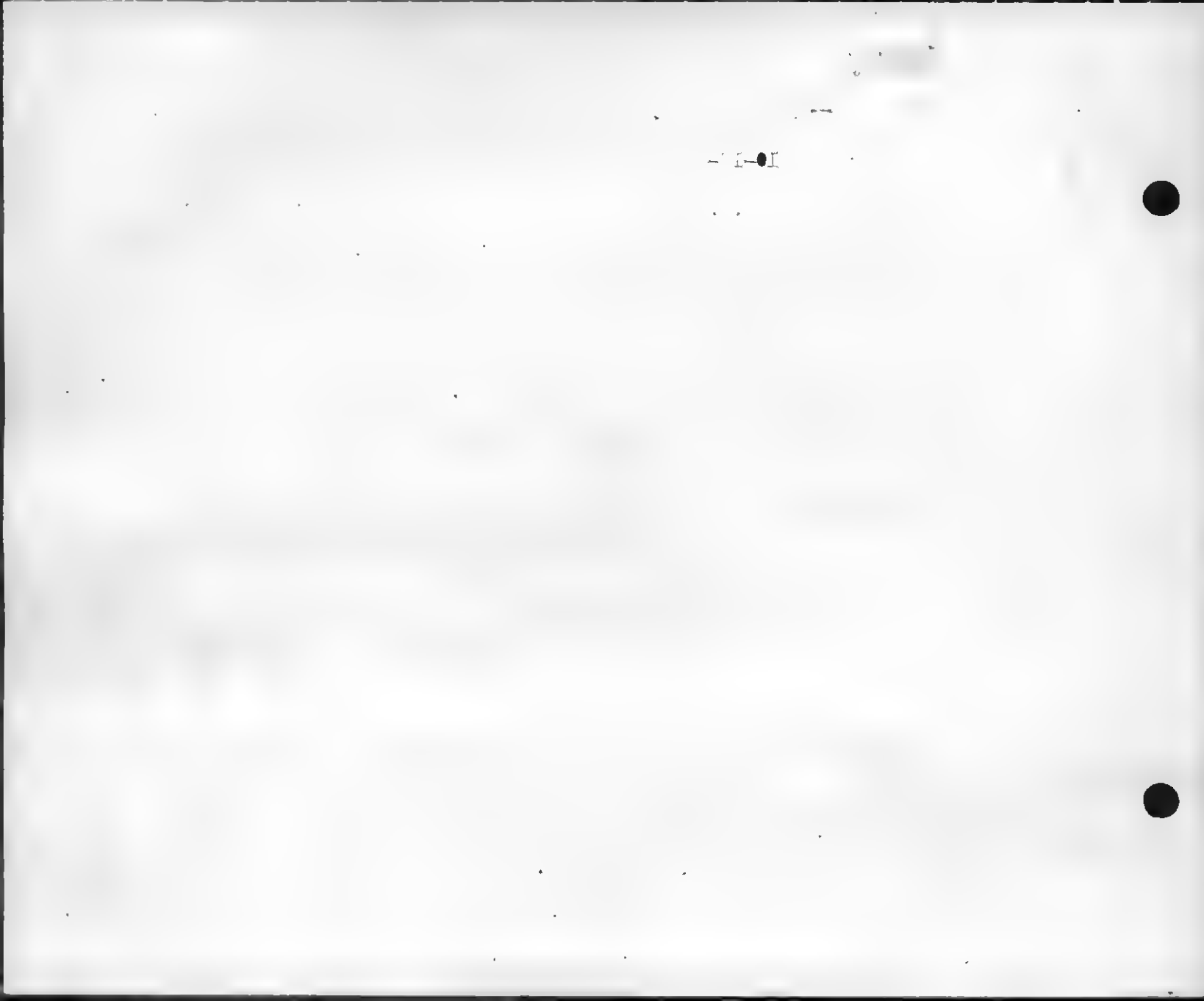


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
HARLEY L. BOOTHE						Month Day Year			1971 00pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	White	10-17-1922	15 YRS	MONTHS DAYS	HOURS MIN	Month Day Year			3 10 68 9:30am		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		
Virginia			U.S.						Prince George's Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Upper Marlboro			Plummers Atlantic Station			Attendant			Gas Station		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Prince George			Upper Marlboro			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
Madison			Boothe			Nancy			Bishop		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. DATE OF OPERATION			20. AUTOPSY?		
Dolly B. Terrell Sister			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intoxication - ethyl alcohol			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Radford, Virginia			39 DUE TO, OR AS A CONSEQUENCE OF								
			(b) DUE TO, OR AS A CONSEQUENCE OF								
			(c) DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. LOCATION Street or R.F.D. No		
CAUSE OF DEATH			19						City or Town		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21g. LOCATION Street or R.F.D. No			City or Town		
									County		
									State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						3-11-68		
John Kehoe MD			Riverdale, Md.			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or town) (County) (State)		
Burial			3/25/68			WHITE ROCK CEMETERY			FLOYD COUNTY VA.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
F. GASCH'S SONS			HYATTSVILLE, MARYLAND			MAR 26 1968			Charles Judge		

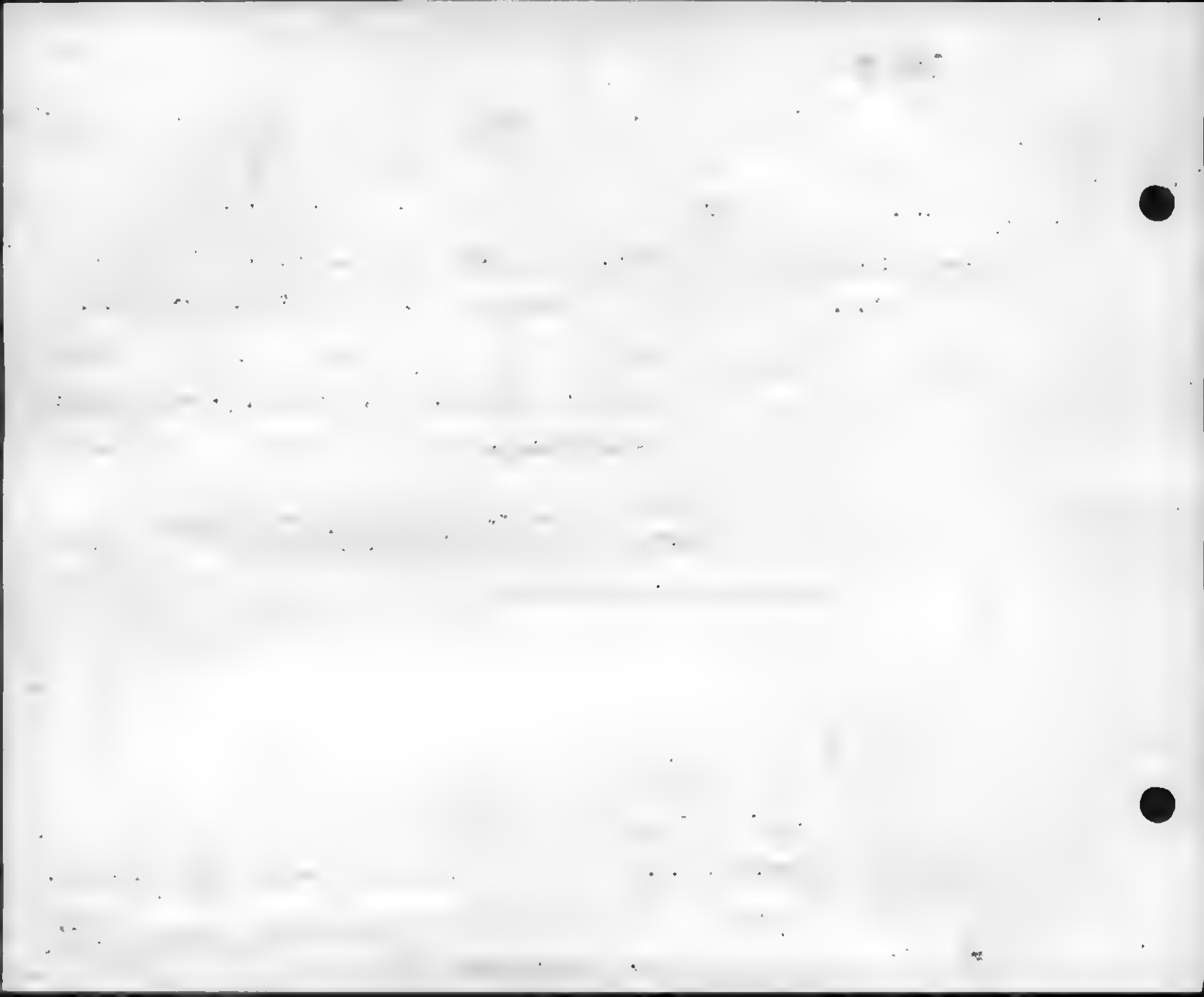


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Sarah E. Bowe</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>28</b> Year <b>68</b>		2b. HOUR <b>12:30p</b>
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>11/08/09</b>		6. AGE (In years last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md		
10. CITY OR TOWN OF DEATH <b>Glenn Dale (rural)</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laundry</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>D.C.</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIM. 1ST? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1424 R. Street, N.W.</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>Commander</b> Last <b>Sylvester</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Sylvester</b> Last <b>Sylvester</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>no</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>578-20-1744</b>	17. INFORMANT <b>Mary L. Bowe, Daughter, same as patient</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>4104</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease with auricular fibrillation</b> (c) <b>congestive heart failure &amp; decompensated</b> <b>years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Generalized Arteriosclerosis</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>3/27</b> , 19 <b>68</b> , to <b>3/28</b> , 19 <b>68</b> , that <b>he</b> (we) lost <b>saw</b> the deceased alive on <b>3/28</b> , 19 <b>68</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) <b>did not</b> view the body after death.					
22b. SIGNATURE <b>Moe Weiss</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>3/28/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22e. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE <b>4/2/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Landover MD.</b>		
24. FUNERAL DIRECTOR <b>P.N. Hatcher Co</b>		ADDRESS <b>1324 You St NW</b>		25a. RECEIVED BY REGISTRAR <b>APR 2 - 1968</b> DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

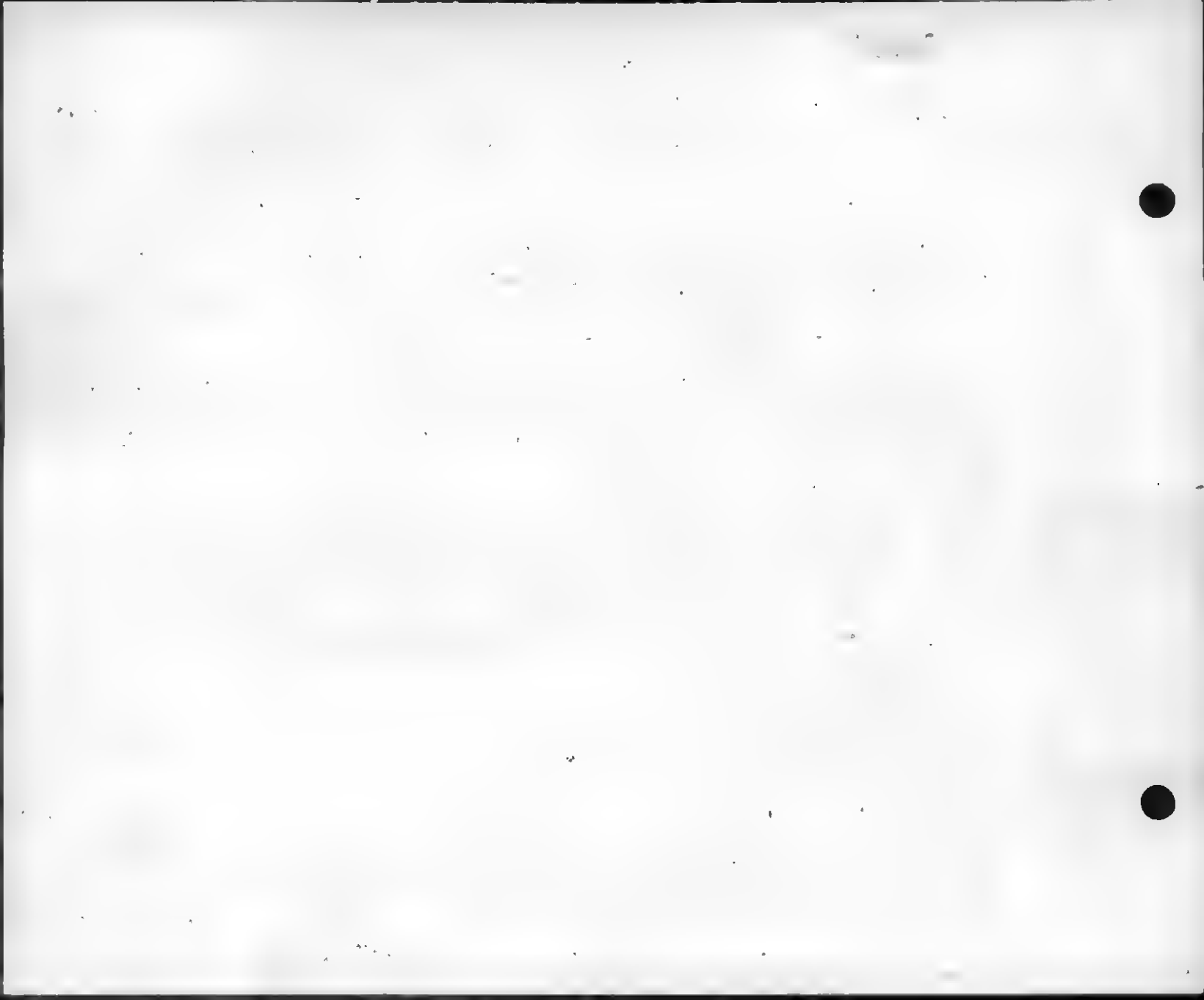




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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Daisy A, Boywell			2a. DATE OF DEATH March Month 4 Day 68 Year 12/45 A M				2b. HOUR					
3 SEX female		4 RACE white		5. DATE OF BIRTH 5/12/85		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? Usa		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md						
10 CITY OR TOWN OF DEATH Riverdale			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b KIND OF BUSINESS OR INDUSTRY home			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b COUNTY Prince Georges			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 4719 Edgewood Road				
14 FATHER'S NAME First Middle Last Charles Sanford			15 MOTHER'S MAIDEN NAME First Middle Last Suellen Rowe									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO. 579 12 3279			17 INFORMANT hospital records			Address Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) BRONCHO? NEUMONIA 2 WEEKS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PARKINSON'S DISEASE												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2-19, 1968, to 3-4, 1968, that (I) (we) lost saw the deceased alive on 3-3-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE C. J. Houmann		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4 MARCH 68		
22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22e. ADDRESS RIVERDALE MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 6, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.						
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 7 1968		25b. REGISTRAR'S SIGNATURE [Signature]				

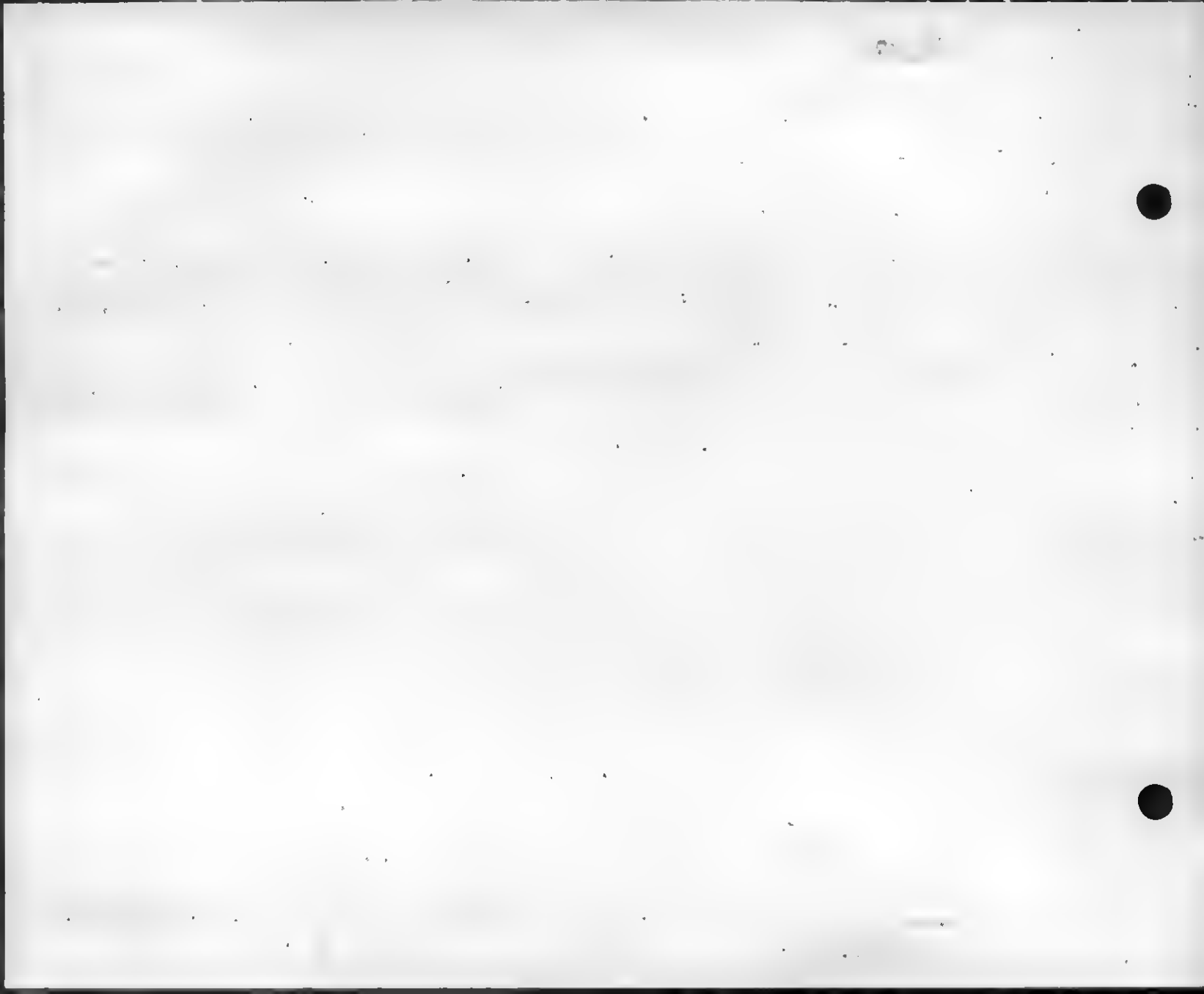


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1  
04530  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH  
0452

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 3:10 PM	
James		L.	Brannan		March 2, 1968			
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
male	white		Sept 24, 1909		58 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Washington D.		C. U S A				Prince George's Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		6312 Inwood St Cheverly Md		Retired Optical Ins.		U S Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, M.T.S?		13e. STREET AND NUMBER
Maryland		Prince George's		Cheverly		YES <input type="checkbox"/> NO <input type="checkbox"/>		6312 Inwood st Cheverly, Md.
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
Joseph C Brannan				Mary G. Tice				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
no		579 07 6851		Margaret A Brannan		Cheverly, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>62</u> , to <u>3-1-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-1-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>John Kehoe</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-4-68		
22d. PHYSICIAN'S NAME (Type) <u>John Kehoe MD</u>				22e. ADDRESS <u>Riverdale, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		March 6, 1968		Cedar Hill Cemetery		Suitland Pro George, Judge		
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REG-STRAR DATE <u>MAR 7 1968</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. 5 may be retained for your files.

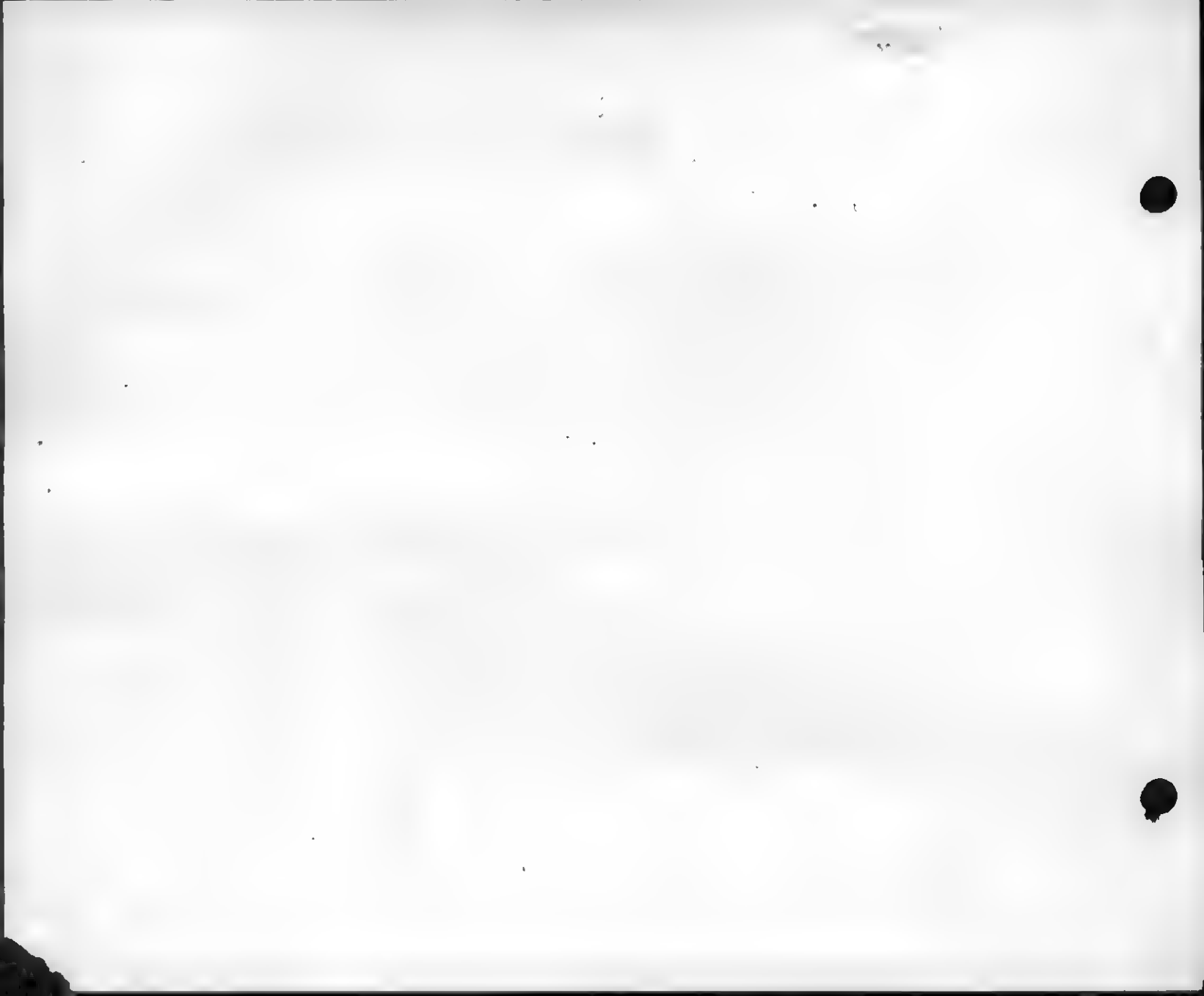
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04531

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH				Month	Day	Year	2b. HOUR
Fannie B Branson						3-13-68				12	30	PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years as of birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	Negro	28 Sept. 1908	59 YRS	MONTHS	DAYS	HOURS	MIN	Month 3 Day 13 Year 68				12:30 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH				Md	
Baltimore, Md.		USA		WIDOWED		DIVORCED		Prince George's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince George Hospital			Practical Nurse			Funeral				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
District of Columbia			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			302 16th St., S.E.				
4. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
John Proctor						Josephine Harley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
						Benjamin Branson			same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure												over 1 hr.	
DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease												over 6 mo.	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
													YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH			P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED	
John Kehoe MD			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			3-14-68				
ADDRESS (Street, City, Town, or County)													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			3-16-68			LINCOLN MEMORIAL			SUITLAND, Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
TOLLINS, INC.			4339 HUNT PL. NE.			MAR 15 1968			Charles Judge				

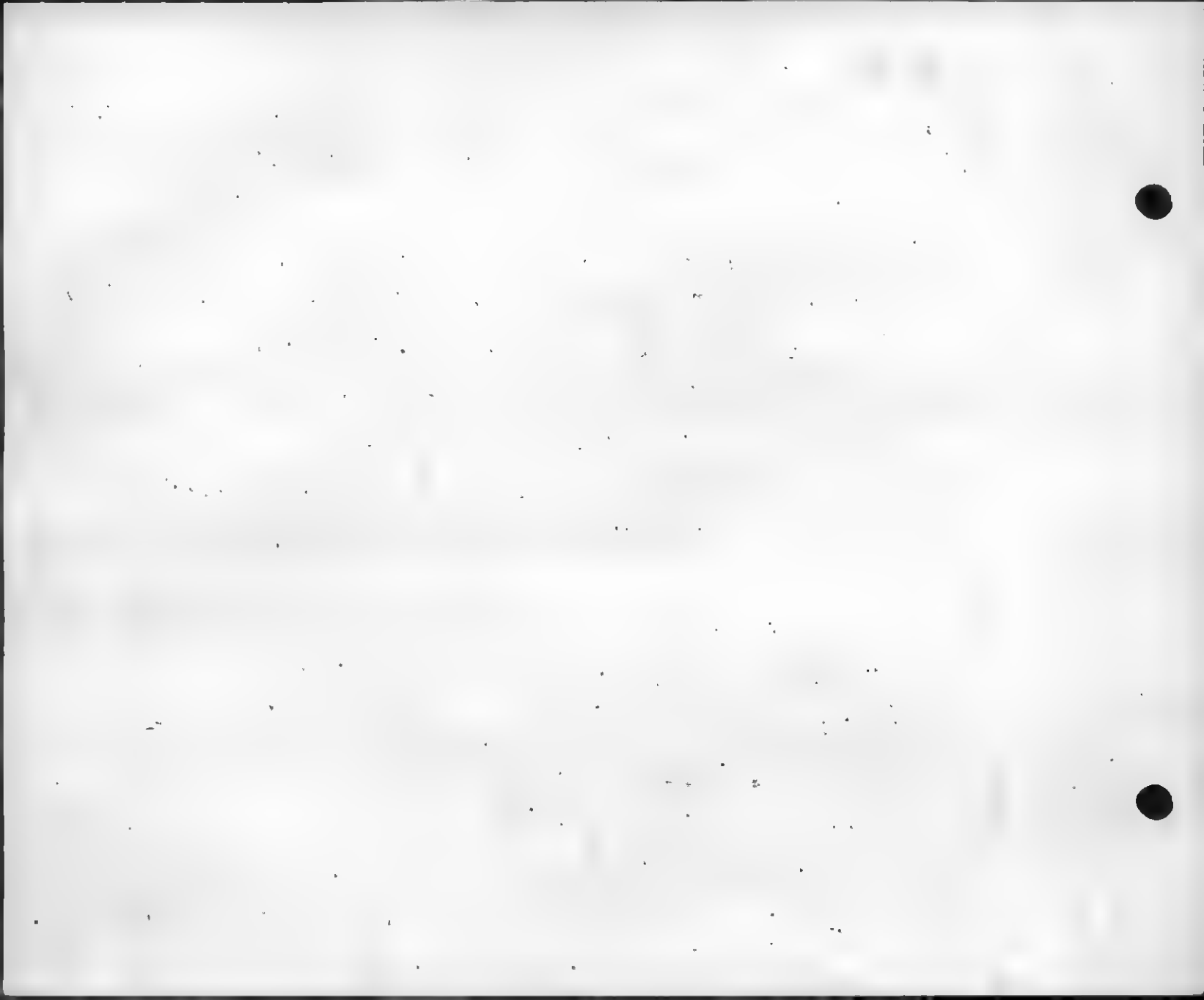


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>Chester McMillian</b>		First Middle Last		2a DATE OF DEATH <b>MAR 3 1968</b>		2b HOJR <b>5:45</b> M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>12-2-1880</b>		6 AGE (In years last birthday) <b>80</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George</b> Md	
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address). <b>Pine View Gardens</b>		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>Engineer</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>		13b COUNTY <b>Arlington</b>		13c CITY OR TOWN <b>Arlington</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>4409 North 17th St.</b>		14. FATHER'S NAME First Middle Last <b>Thomas Bray</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Ella J. McMillian</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Unknown</b>		16b SOCIAL SECURITY NO. <b>579-03-5668-A-B</b>		17. INFORMANT <b>Margaret Grimes LPN</b>		Address <b>Lot 25 RFD Box 43 Upper Marlboro MD</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>TERMINAL BRONCHOPNEUMONIA 12 HRS.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED CARCINOMATOSIS - BRONCHOGENIC CA 5 1/2 MOS.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>NONE</b>							
19a. DATE OF OPERATION <b>OCT '67</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRONCHOGENIC CA</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <b>None</b> Month <b>None</b> Year <b>1967</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <b>None</b>		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC. <b>None</b>		21f. LOCATION Street or R.F.D. No <b>None</b> City or Town <b>None</b> County <b>None</b> State <b>None</b>			
22a. I certify that (1) (this hospital) attended the deceased from <b>Oct 30, 1967</b> to <b>Present</b> , that (1) (we) lost saw the deceased alive on <b>March 2, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Arthur Shaver Jr</b>		22c. DATE SIGNED <b>3/3/68</b>		22d. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR</b>		22e. ADDRESS <b>8808 BRANCH AVE. CLINTON, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>3/6/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>National Memorial Pk.</b>		23d LOCATION (City or Town) (County) (State) <b>Falls Church Fairfax Va.</b>	
24 FUNERAL DIRECTOR <b>Wm. H. Morgan</b>		ADDRESS <b>Arlington, V.</b>		25a REC'D BY REGISTRAR <b>DATE MAR 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





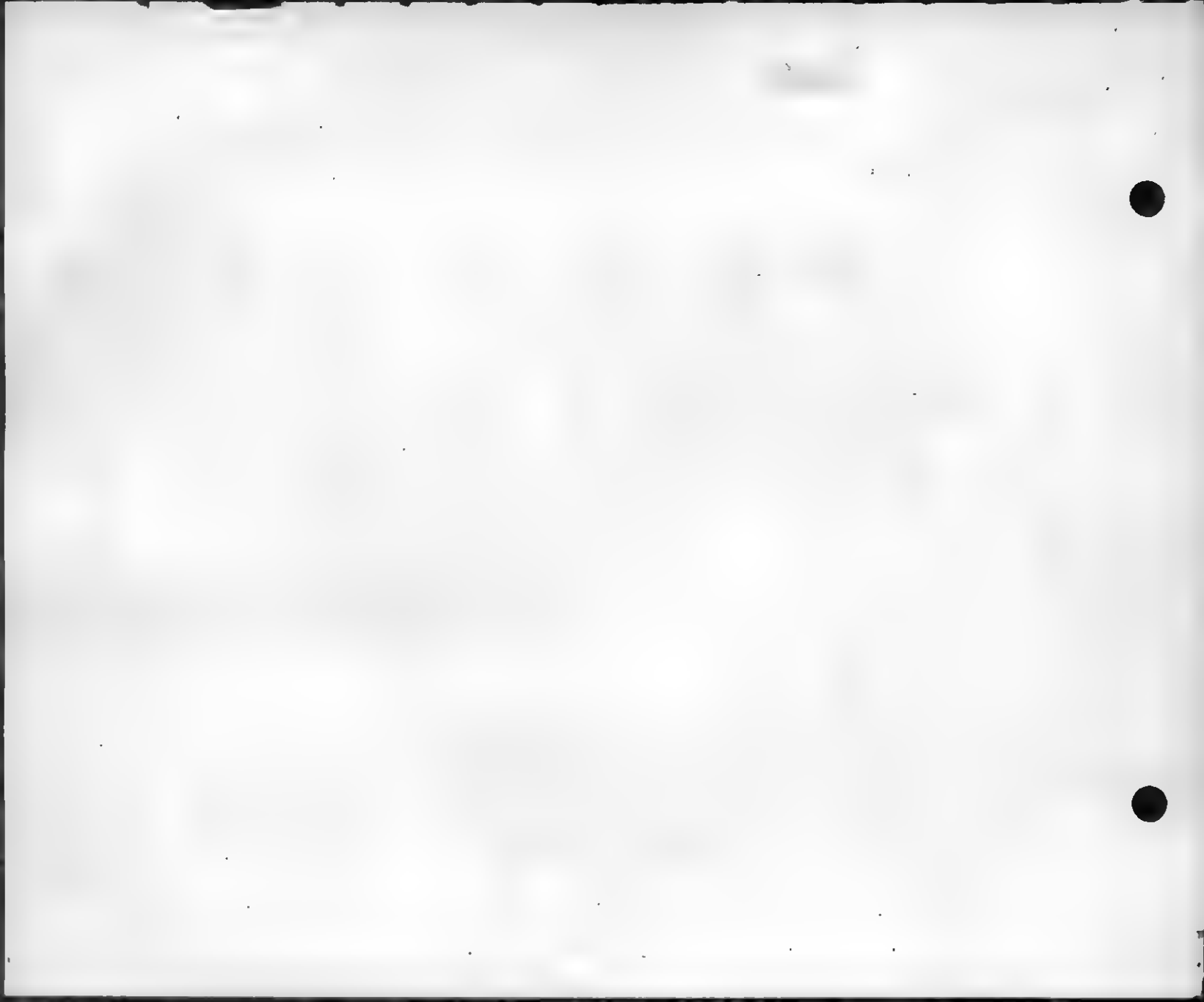
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04-33

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BADEN</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BADEN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		d. STREET ADDRESS <u>RT 1 BOX 361</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET HYDE BRAY</u>		4. DATE OF DEATH <u>MARCH 23, 1968</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-1913</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IBM OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COURT HOUSE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>P.G., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NORVAL P. HYDE</u>		14. MOTHER'S MAIDEN NAME <u>RHODA C. HYDE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-20-8089</u>	
17. INFORMANT <u>GARY A. BRAY, BADEN, MD.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary Carcinoma</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Co of ovary</u> DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-17</u> , 19 <u>57</u> to <u>3-23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-23</u> , 19 <u>68</u> and that death occurred at <u>8:00</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3-23-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>BRADY WINE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-26-68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST PAULS</u>		23d. LOCATION (City, town or county) (State) <u>BADEN, MD.</u>	
24. FUNERAL DIRECTOR <u>HUNTT FUNERAL HOME, WALDORF, MD.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MAR 27 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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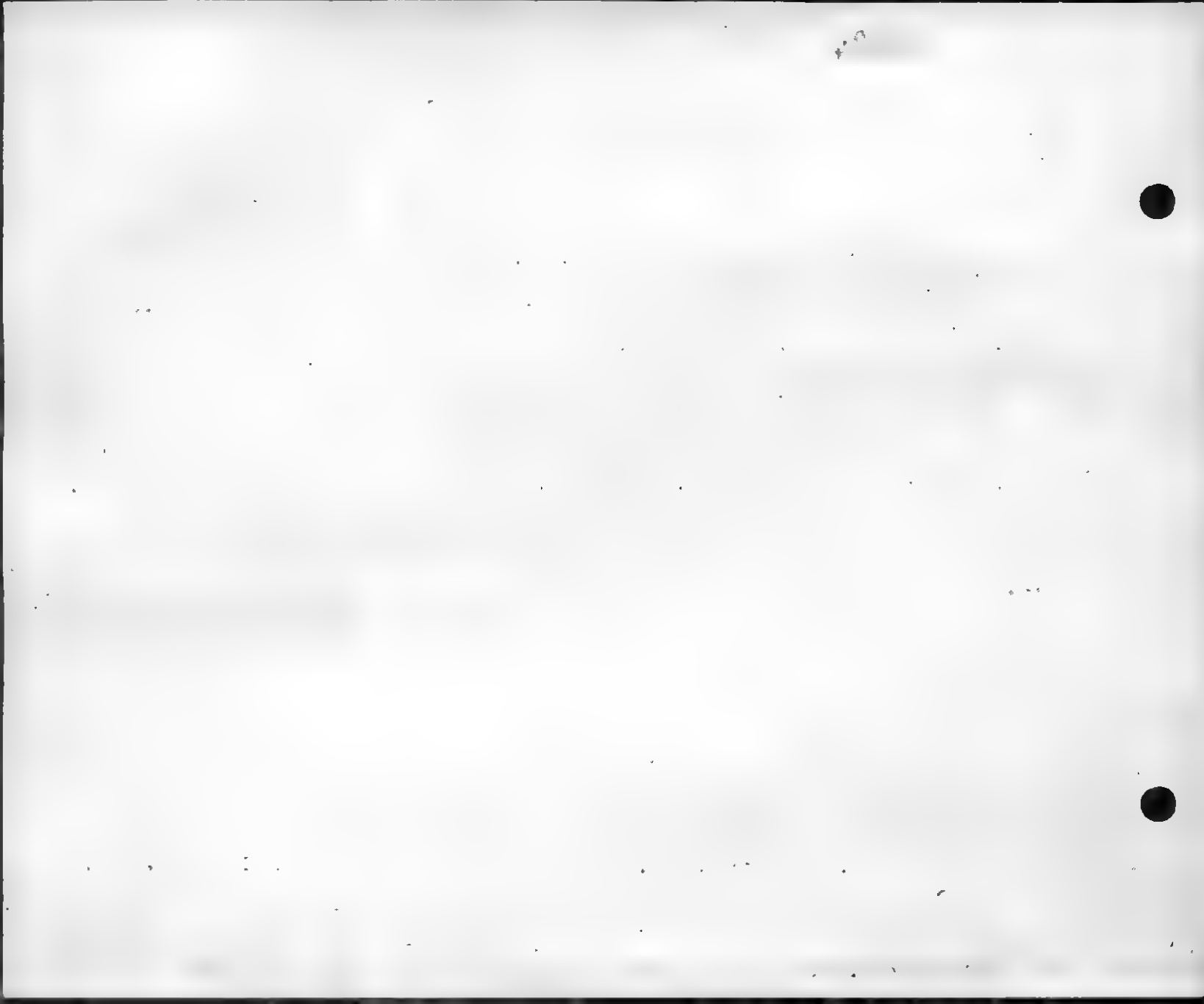
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30M REV. 7-68

04534

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

J4526

1. DECEASED NAME (Type or print)		First Ethel		Middle Briggs		Last Briggs		2a. DATE OF DEATH 3 Month 25 Day 68 Year				2b. HOUR 1:00 PM	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 8-8-11				6. AGE (In years last birthday) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.							
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4509 Banner St.					
14. FATHER'S NAME First Howard		Middle Graham		Last Graham		15. MOTHER'S MAIDEN NAME First Sarah		Middle Wallace		Last Wallace			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Medical Records				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: Carcinomatosis IMMEDIATE CAUSE (a) <u>16.4.1</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic CA Right lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>16.4.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 4 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>15.2</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>66</u> , to <u>3-25-68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>3-14-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>C. J. Houmann</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-25-68							
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.		22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-30-68		23c. NAME OF CEMETERY OR CREMATORY Queens Chapel		23d. LOCATION (City or Town) Moorpark Rd		(County)		(State)			
24. FUNERAL DIRECTOR <u>H.S. Washington</u>		ADDRESS 4925 Dunc		25a. REC'D BY REGISTRAR DATE APR 2 - 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



Items 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 2j, 2k, 2l, 2m, 2n, 2o, 2p, 2q, 2r, 2s, 2t, 2u, 2v, 2w, 2x, 2y, 2z

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form, Form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) <b>WILLIAM BROWN</b>		2a DATE KNOWN OF DEATH ESTIMATED <b>March 24, 1968</b>		2b HOUR OF DEATH <b>1:30 AM</b>	
3 SEX <b>M</b>	4 RACE <b>C</b>	5 DATE OF BIRTH <b>May 17 1917</b>	6 AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>
7a BIRTHPLACE (State or foreign country) <b>South Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH <b>Prince Georges</b>		10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Princess General Hospital</b>	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Clay</b>		12b INDUSTRY <b>Clay</b>		13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>DC</b>	
13b COUNTY <b>Wash.</b>		13c CITY OR TOWN <b>Wash.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>1407 Lunaloka NE</b>		14 FATHER'S NAME First <b>Thomas</b> Middle <b>Brown</b> Last <b>Brown</b>		15 MOTHER'S MAIDEN NAME First <b>Odessa</b> Middle <b>Brown</b> Last <b>Brown</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. <b>Odessa Brown</b>		17 INFORMANT <b>Wash.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Surgical Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Wounds multiple &amp; Severe</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>last</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. <b>19</b> P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Struck by moving car</b>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No. <b>RFD 495</b> City or Town <b>Faurel</b> County <b>Pr. Georges</b> State <b>MD</b>	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dayton Watkins</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>3-25-68</b>	
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>3-29-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>	
23d LOCATION (City or Town) <b>Suitland</b>		23e LOCATION (County) <b>Maryland</b>		23f LOCATION (State)	
24. FUNERAL DIRECTOR <b>John T. Rhines Co. 3015 12th St., N. E.</b>		25a REC'D BY REGISTRAR <b>Wash. D.C.</b>		25b REGISTRAR'S SIGNATURE <b>John T. Rhines</b>	



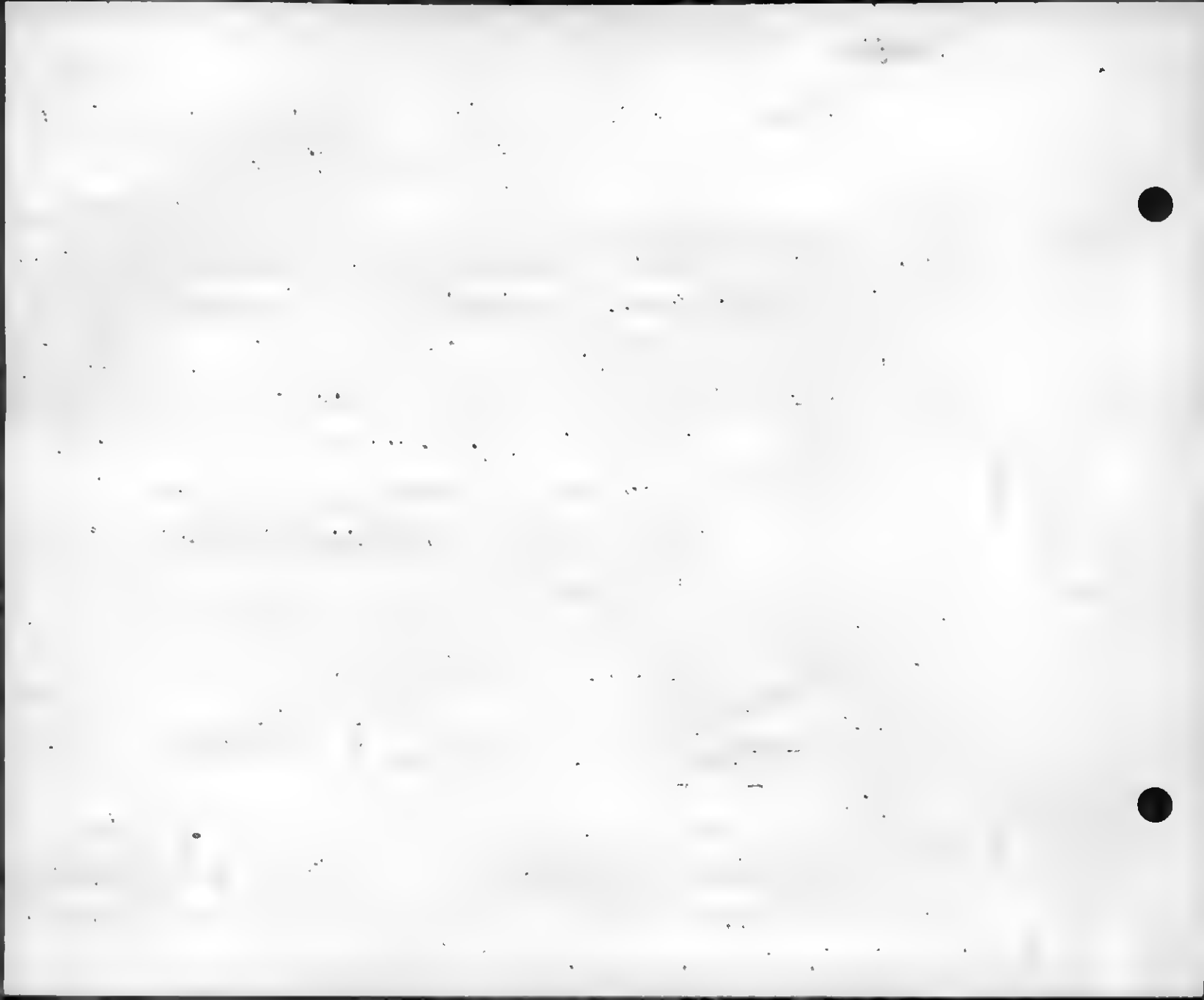
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VR 15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>DONALD HARVEY BUCK</b>			2a. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>7:30 PM</b>	
3 SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>APRIL 18-1894</b>		6. AGE (In years last birthday) <b>73</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7813 CIRCLE DR.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CABINET MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPL.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>PR. GEO.</b>		13c. CITY OR TOWN <b>CLINTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>7813 CIRCLE DR.</b>		14. FATHER'S NAME First Middle Last <b>AMON BUCK</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY ELIE FARR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO <b>1916-1918</b>		17. INFORMANT <b>MABEL BUCK (WIFE)</b>		Address <b>7813 CIRCLE DR. - CLINTON</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>1124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CEREBROVASCULAR ACCIDENT, ACUTE 12 HRS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC CARDIO-VAS. DISEASE 13 1/2 HRS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221 None</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR COMPLICATING CAUSE OF DEATH (If either, notify medical examiner) <b>None</b>		21b. TIME OF INJURY HOUR A.M. <b>None</b> P.M. <b>None</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>			
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or while at work <b>None</b>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>None</b>		21f. LOCATION Street or R.F.D. No <b>None</b> City or Town <b>None</b> County <b>None</b> State <b>None</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 1959</b> to <b>PRESENT</b> , that (I) (we) last saw the deceased alive on <b>MAR 24 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Arthur Shaver Jr MD</b>						22c. DATE SIGNED <b>3/24/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAYER JR MD</b>						22e. ADDRESS <b>8808 BRANCH AVE - CLINTON MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 27, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery - Bladensburg, Maryland</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Prince Georges, MD</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros. 1661-Gd. Hope Rd. BE. DC</b>				25a. REC'D BY REGISTRAR <b>MAR 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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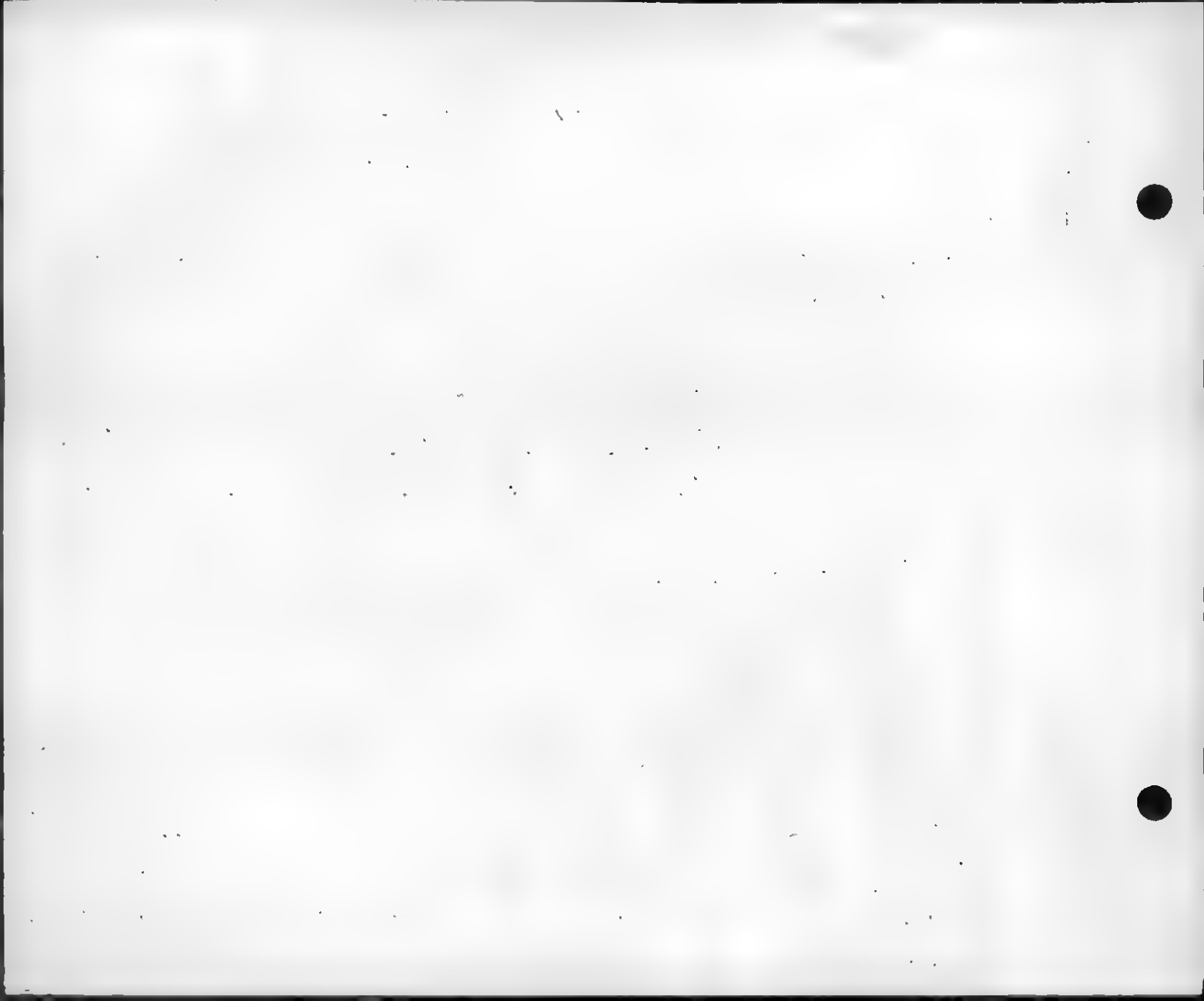
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Sister ANNE FRANCES BYRNE			First Middle Last			2a. DATE OF DEATH Month 3 Day 20 Year 1968			2b. HOUR 9:50 P.M.				
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH DEC 13, 1891			6 AGE (In years last birthday) 76 YRS			7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) ROANOKE, VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGES Md							
10 CITY OR TOWN OF DEATH HYATTSVILLE, MD.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL MANOR			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RELIGIOUS, NUN			12b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND HOUSE NO. 4001 OLD GEORGETOWN ROAD.	
14. FATHER'S NAME First Middle Last JAMES J. BRESLIN			15. MOTHER'S MAIDEN NAME First Middle Last ALICE TOOMEY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-58-5229			17 INFORMANT Sister M. Daloue			Address 4822 LASALLE Rd. HYATTSVILLE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 332X (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 mos. 10 yr.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetic mellitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21c. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July, 1967, to 20 March 1968, that (I) (we) last saw the deceased alive on 20 March 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Joseph J. Wallace M.D.											22c. DATE SIGNED 20 March 1968		
22d. PHYSICIAN'S NAME (Type) JOSEPH J. WALLACE M.D.											22e. ADDRESS 1830 K ST. N.W. WASH. D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3-22-68			23c. NAME OF CEMETERY OR CREMATORY VISITATION GAVENT CEMETERY			23d. LOCATION (City or Town) (County) (State) BETHESDA MONTGOMERY, MD.				
24. FUNERAL DIRECTOR Francis J. Collins			3821 14th St N.W. Wash. D.C.			25a. REC'D BY REGISTRAR DATE MAR 26 1968			25b. REGISTRAR'S SIGNATURE Francis J. Collins				

MEDICAL CERTIFICATION



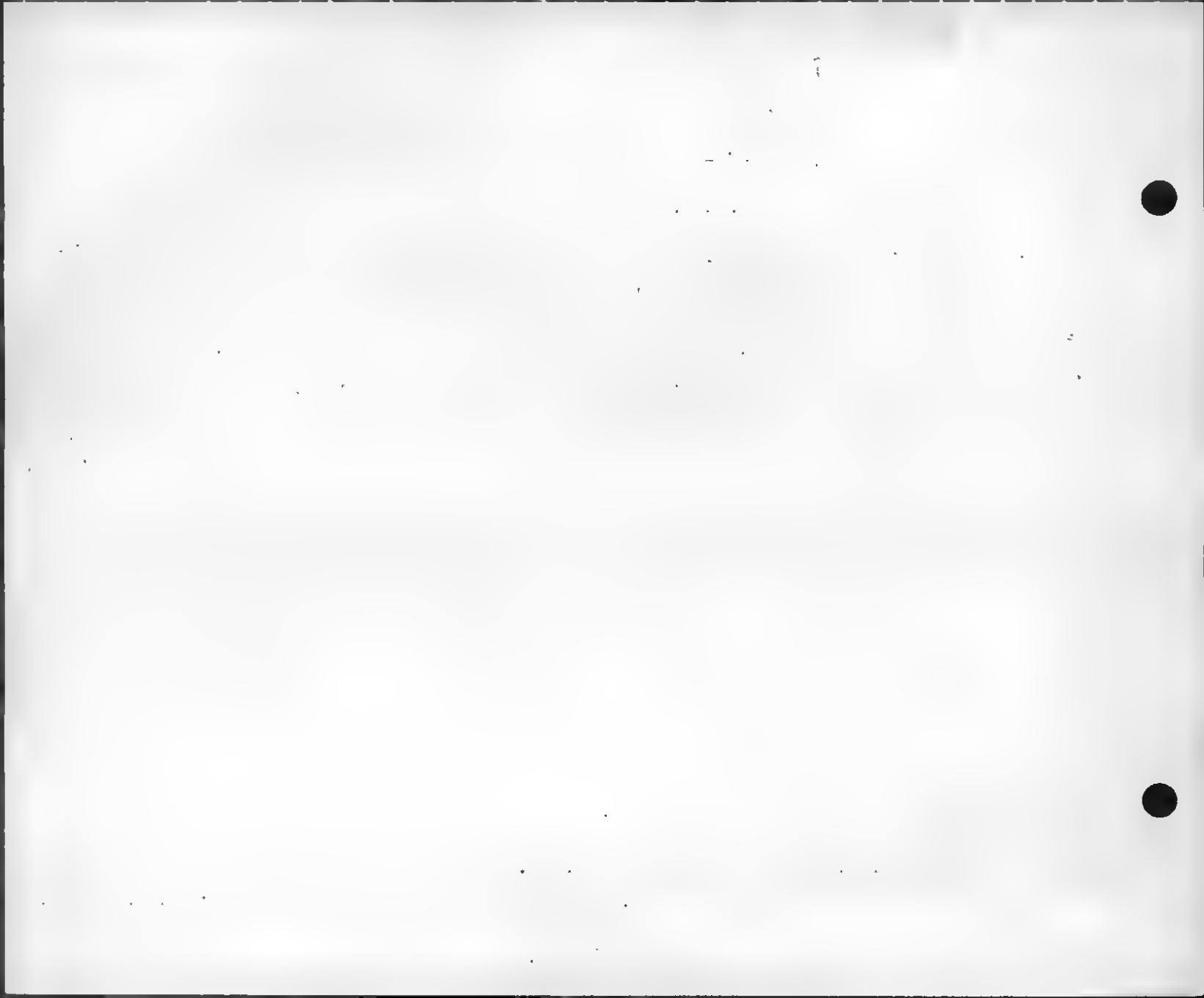
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 34537 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Charles Arthur Caldwell			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3-17-68 19 1:10pm			2b. HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-26-1911	6 AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3 Day 17 Year 68 1:19pm M		
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Radio Engineer		12b. KIND OF BUSINESS OR INDUSTRY Government
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Cheverly	3d. INSIDE CITY, APTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Alvin B. Caldwell			15. MOTHER'S MAIDEN NAME Clara J. Jessie			13e. STREET AND NUMBER 6007 Kilmer Street		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 380 01 8796		17 INFORMANT Maryse Caldwell Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Riverdale, Md.			22b. DATE SIGNED 3-18-68		
23a. BURIAL CREMATION (If HOW, specify) Burial		23b. DATE 3/18/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAR 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>9</u> , Day <u>9</u> , Year <u>1968</u>		2b. HOUR <u>2:05PM</u>	
Baby Girl "B" CARR								
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 9, 1968		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		Md.
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen'l Hospital		12a. USJA. OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5302 Hamilton Street
14. FATHER'S NAME William Marvin Carr		First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary Jane Brown		First	Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Mother		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (A) (this hospital) attended the deceased from <u>March 9, 1968</u> , to <u>March 9, 1968</u> , that (1) (we) last saw the deceased alive on <u>March 9, 1968</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death								
22b. SIGNATURE <u>Joseph A. Murgalo</u>		22c. DATE SIGNED March 13, 1968		22d. PHYSICIAN'S NAME (Type) Joseph A. Murgalo, M. D.		22e. ADDRESS Prince George's General Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/23/68		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland		
24. FUNERAL DIRECTOR <u>John W. P... JR.</u>		ADDRESS ADMINISTRATOR		25a. REC'D BY REGISTRAR DATE <u>March 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



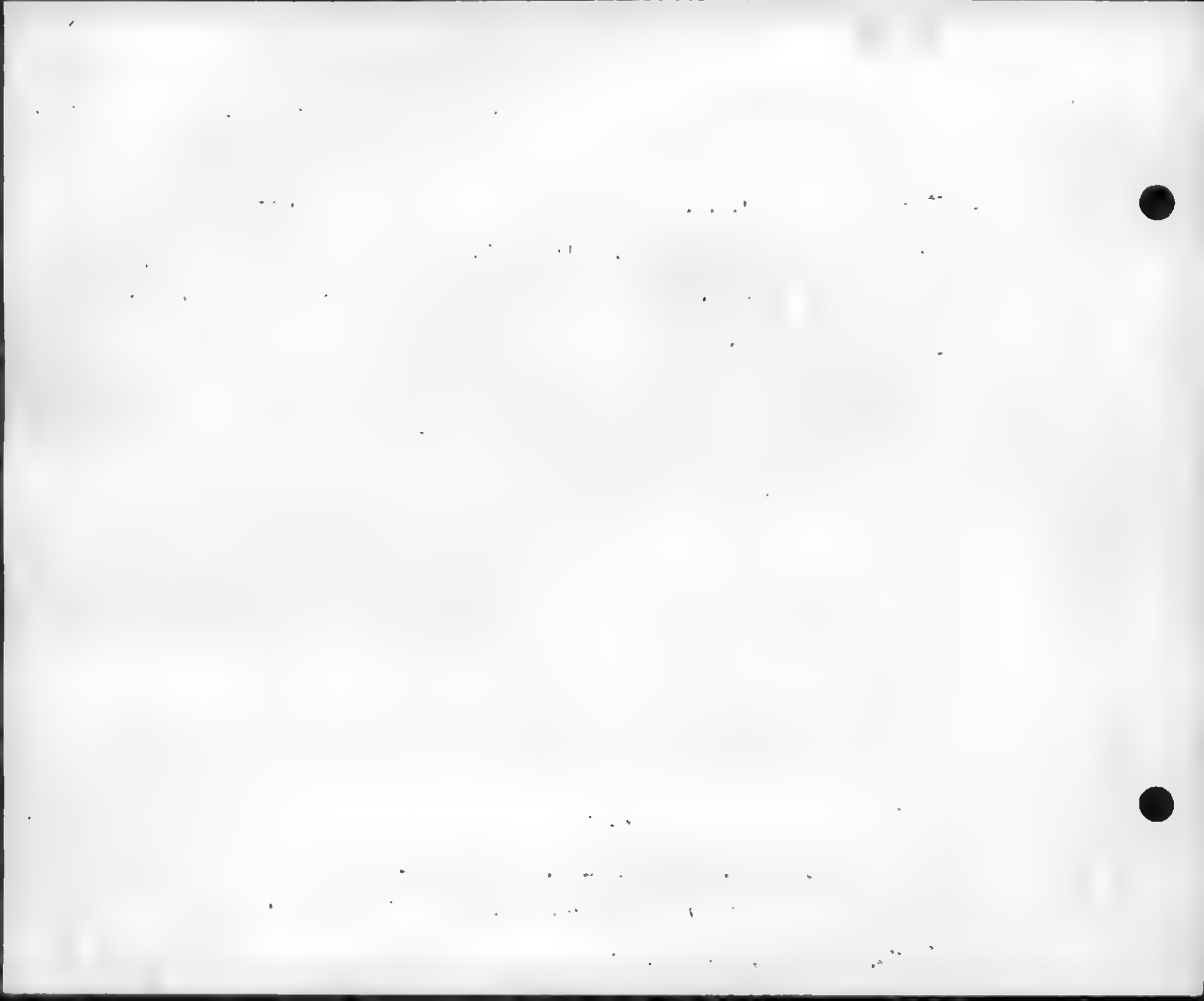
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MD 33  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

34533

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 7:10 PM	
Baby Boy "C" CARR					March 9, 1968			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH March 9, 1968		6. AGE (n years last birthday) YRS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.		10. UNDER 24 HRS HOURS MIN
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5302 Hamilton Street
14. FATHER'S NAME First Middle Last William Marvin Carr		15. MOTHER'S MAIDEN NAME First Middle Last Mary Jane Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Mother
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>XX</del> (this hospital) attended the deceased from March 9, 1968, to March 9, 1968, that (X) (we) last saw the deceased alive on March 9, 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Joseph A. Murgalo, M.D.</u>		22c. DATE SIGNED March 13, 1968		22d. PHYSICIAN'S NAME (Type) Joseph A. Murgalo, M. D.		22e. ADDRESS Prince Georges General Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/23/68		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland		
24. FUNERAL DIRECTOR <u>W. J. BERRY, JR.</u>		ADDRESS ADMINISTRATOR		25a. REC'D BY REGISTRAR DATE MAR 27 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





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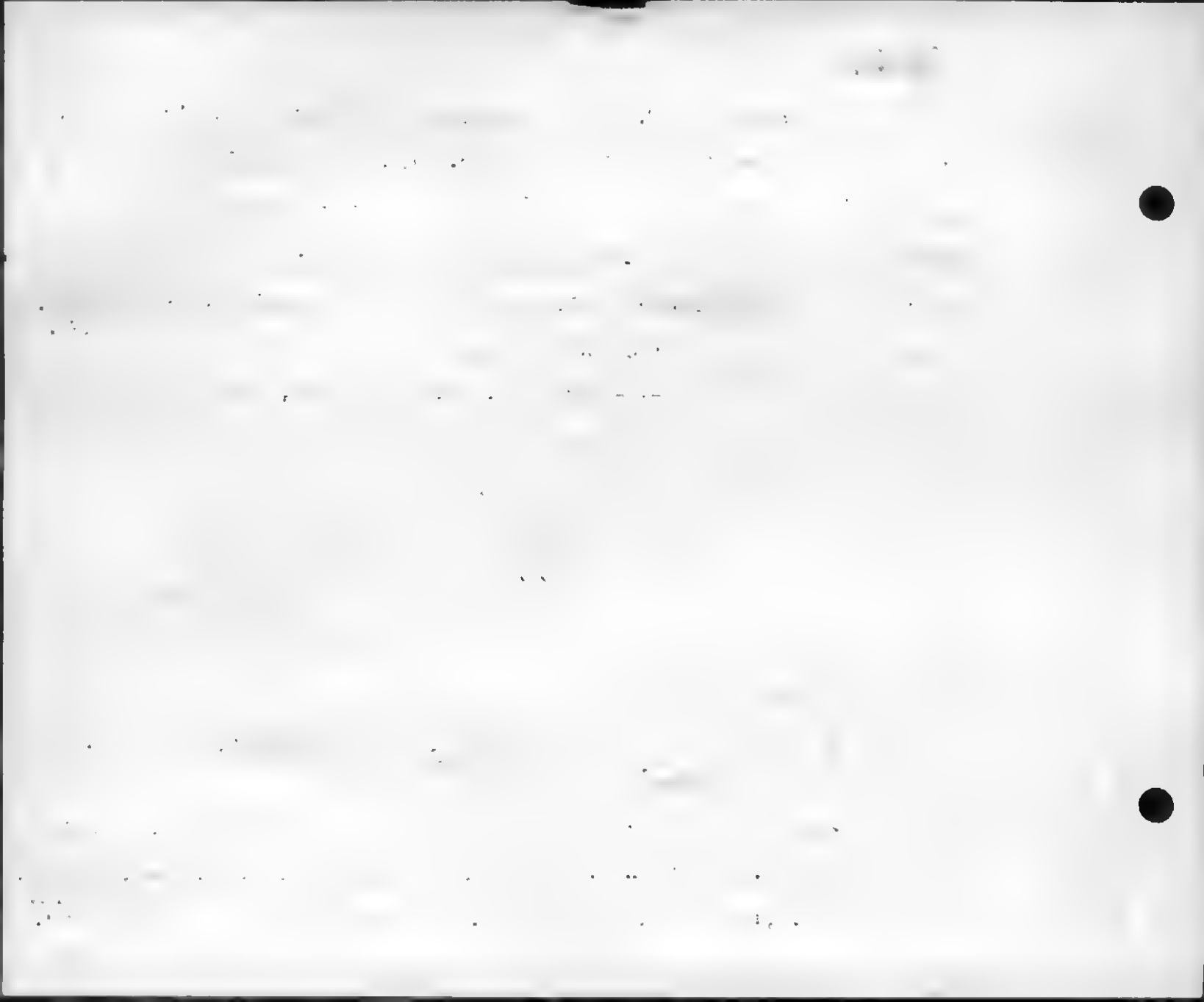
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Ralph S. Catterton</b>			2a. DATE OF DEATH Month Day Year <b>March 6, 1968</b>		2b. HOUR <b>2:30 P</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Aug. 25, 1918</b>		6. AGE (In years last birthday) <b>55-56 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges Md</b>		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Attendant</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Bristol</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>c/o Harold Cox-Pindell Rd.</b>	
14. FATHER'S NAME First Middle Last <b>James Catterton</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosie Chaney Bristol, Md.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-12-9646</b>	17. INFORMANT Address <b>Mrs. Ruth Catterton, Bristol, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension - Vascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (this hospital) attended the deceased from <u>March 2, 1968</u> , to <u>March 6, 1968</u> , that (we) last saw the deceased alive on <u>March 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <i>Edwin J. Jensen</i> DEGREE <b>Edwin J. Jensen, M. D.</b>				22c. DATE SIGNED <b>March 7, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M. D.</b>				22e. ADDRESS <b>Prince Georges General Hospital, Cheverly</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 9, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Harmony Chr. Cemetery Owings</b>		23d. LOCATION (City or Town) (County) (State) <b>Calvert Md.</b>
24. FUNERAL DIRECTOR <i>Funeral Home</i> <b>Funeral Home</b>			25a. REC'D BY REGISTRAR <b>MAR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>

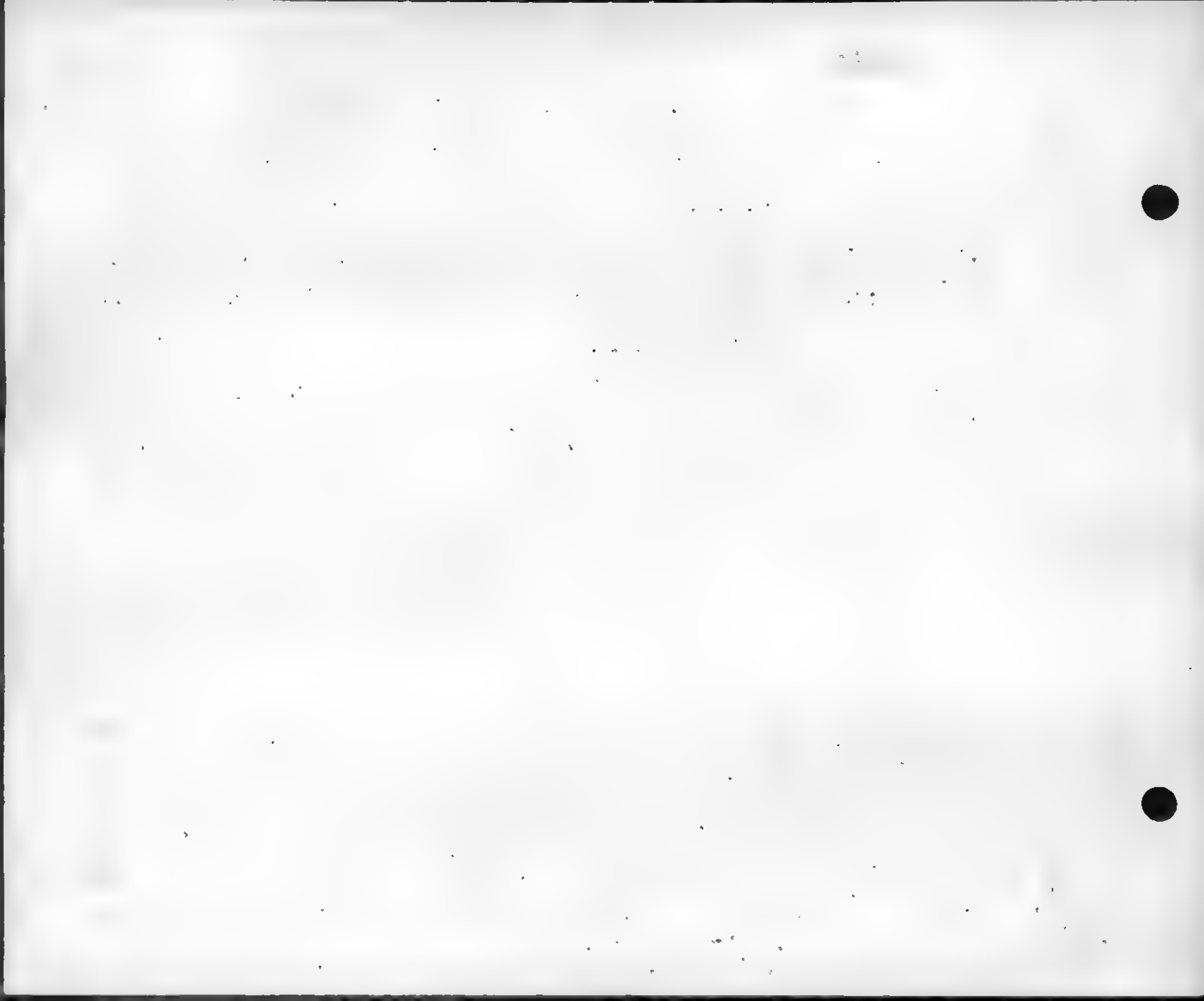


**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) First Middle Last <b>JAMES EDWARD CAULFIELD</b>			2a. DATE OF DEATH Month Day Year <b>MAR 4 68</b>			2b. HOUR A <b>6:45M</b>				
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH <b>12 JUN 28</b>		6 AGE (In years lost birthday) <b>39</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MASS.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>PRINCE GEORGE'S Md</b>				
10 CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAFH</b>			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <b>RETIRED AF OFF.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>MILITARY</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>BOWIE</b>		13c. CITY OR TOWN <b>BOWIE</b>		13d. INSIDE CITY "IN" YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3004 TWISTING LANE</b>	
14 FATHER'S NAME First Middle Last <b>JAMES EDWARD CAULFIELD</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>HELEN MURPHY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) <b>YES</b>			16b. SOCIAL SECURITY NO <b>722 14 7580</b>		17 INFORMANT Address <b>WIFE SAME AS ITEM #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>HODGKIN'S DISEASE</b> <b>201X</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS.</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION <b>201X</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>18 Feb</b> , 19 <b>68</b> , to <b>4 Mar</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>4 Mar</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Allen D. Ward</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>4 March 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>ALLEN D. WARD, CAPT USAF</b>								22e. ADDRESS <b>MALCOLM GROW USAF HOSP ANDREWS</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b>			23d. LOCATION (City or Town) (County) (State) <b>(County) (State)</b>			
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>						25a. REC'D BY REGISTRAR <b>DATE MAR 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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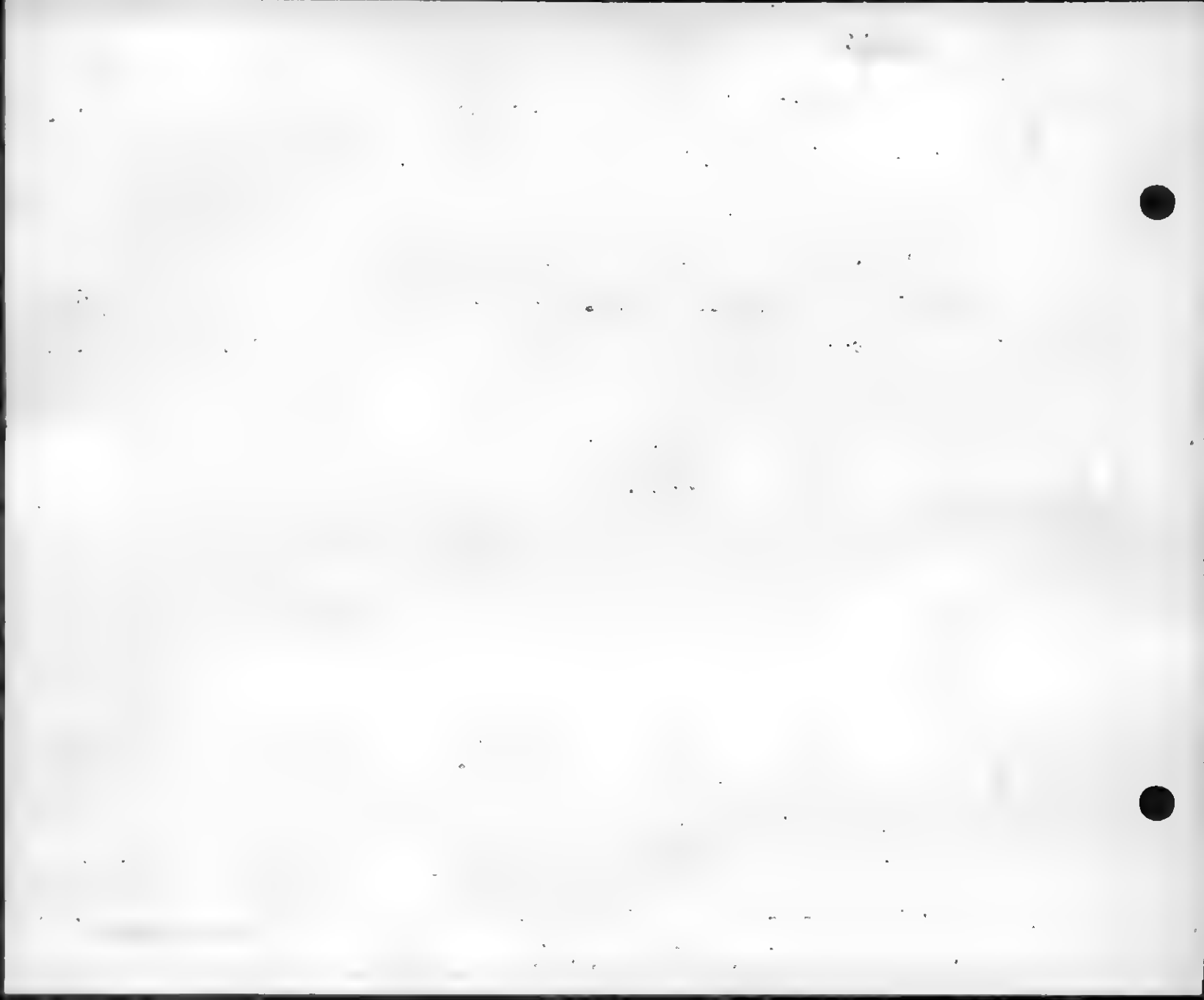
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MD MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>VICTORIA</b>		First <b>ANN</b>		Middle <b>CHAGNON</b>		Last		2a. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>68</b>			2b. HOUR <b>1225</b> A <b>M</b>	
3 SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>23 Mar 68</b>				6. AGE (In years last birthday) <b>26</b> YRS		IF UNDER 1 YEAR MONTHS <b>2</b> DAYS <b>2</b> HOURS <b>2</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.						
10. CITY OR TOWN OF DEATH <b>Andrews AFB</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcolm Grow USAF Hosp</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>3025 Brinkley Road</b>				
14. FATHER'S NAME First <b>Albert</b> Middle <b>George</b> Last <b>Chagnon</b>				15. MOTHER'S MAIDEN NAME First <b>Ann</b> Middle <b>Marie</b> Last <b>Yonkin</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Father</b>		Address <b>same as item 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b>  DUE TO, OR AS A CONSEQUENCE OF (b) <b>Peritonitis</b>  DUE TO, OR AS A CONSEQUENCE OF (c)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>571</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (1) (this hospital) attended the deceased from <b>23 Mar, 1968</b> to <b>26 Mar, 1968</b> , that (1) (we) last saw the deceased alive on <b>26 Mar, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>William E. Palma, Capt USAF MC</b> MD								DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>26 Mar 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM E. PALMA CAPT USAF MC</b>								22e. ADDRESS <b>MALCOLM GROW USAF HOSP ANDREWS</b>				
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>					
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road SE, Washington, D.C.</b>						25a. RECD BY REGISTERED <b>APR 1 - 1968</b> DATE		25b. SIGNATURE <b>[Signature]</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

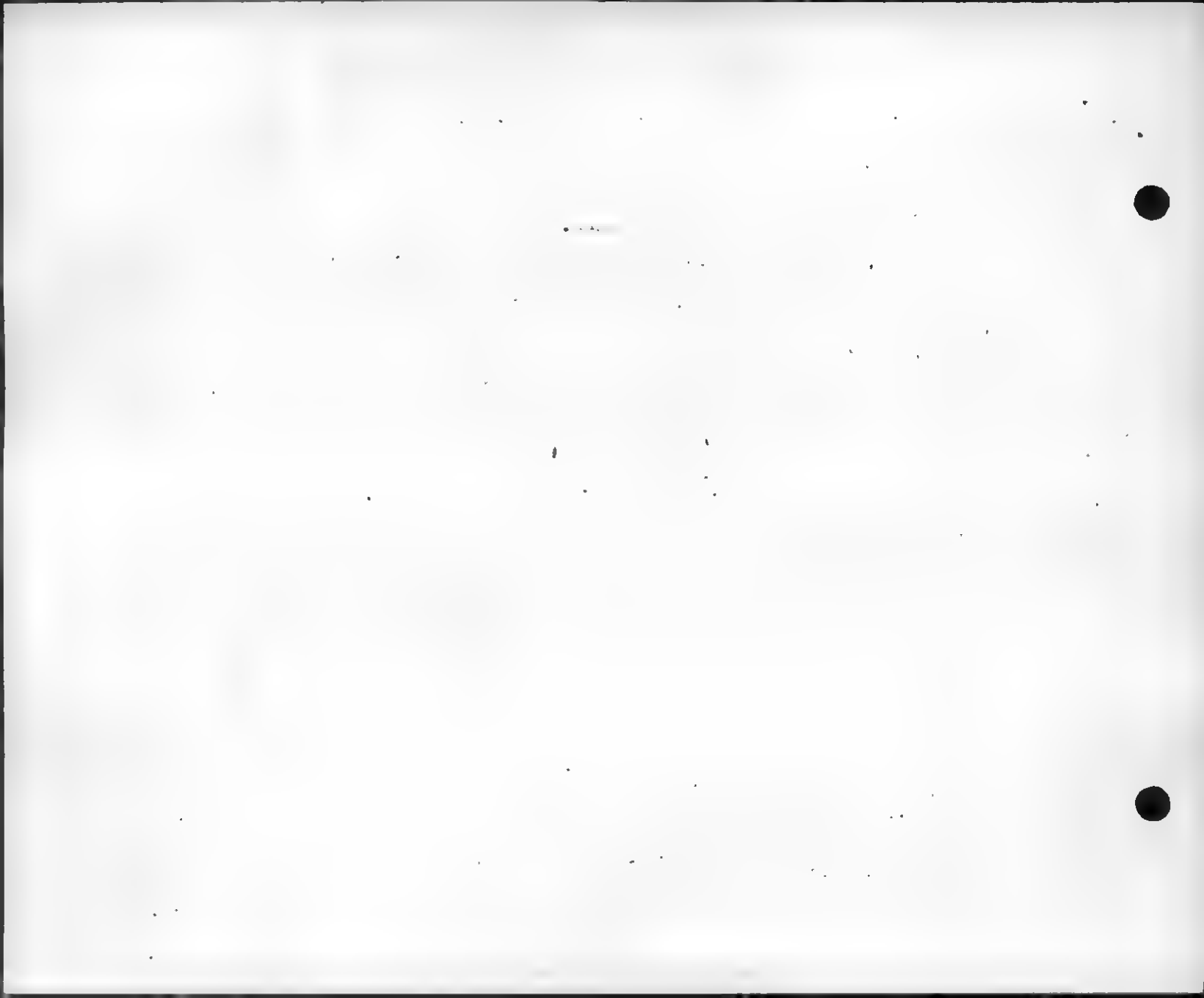
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Items 21a&22a Film 398  
3/21/68 ams  
Item 5 Film G398 3/18/68 kkk

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Emma E. Chaplin</b>			2a. DATE OF DEATH Month <b>Mar</b> Day <b>9</b> Year <b>1968</b> 2b. HOUR <b>4:50 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH <b>2-23-18 1911</b>	
7a. BIRTHPLACE (State or foreign country) <b>Brooklyn N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Clinton Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Clinton Community Receptionist</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Receptionist</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>La Plata</b>	
14. FATHER'S NAME First <b>Thomas</b> Middle <b>Coyne</b> Last <b></b>		15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b></b> Last <b></b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <b>064-05-4132</b>		17. INFORMANT Address <b>Kenneth Chaplin-La Plata, Md. 20646</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>779X BARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BURNS 3rd degree 60% Body surface</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-4</b> , 19 <b>68</b> , to <b>3-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>accident</b>					
22b. SIGNATURE <b>Robert W. Merkle</b>				22c. DATE SIGNED <b>3-9-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ROBERT W. MERKLE</b>				22e. ADDRESS <b>CLINTON, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>	
23d. LOCATION (City or Town) <b>LA PLATA CHARLES, MD.</b>		23e. LOCATION (County) <b></b>		23f. LOCATION (State) <b></b>	
24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WALDORF, MD.</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 14 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b></b>	



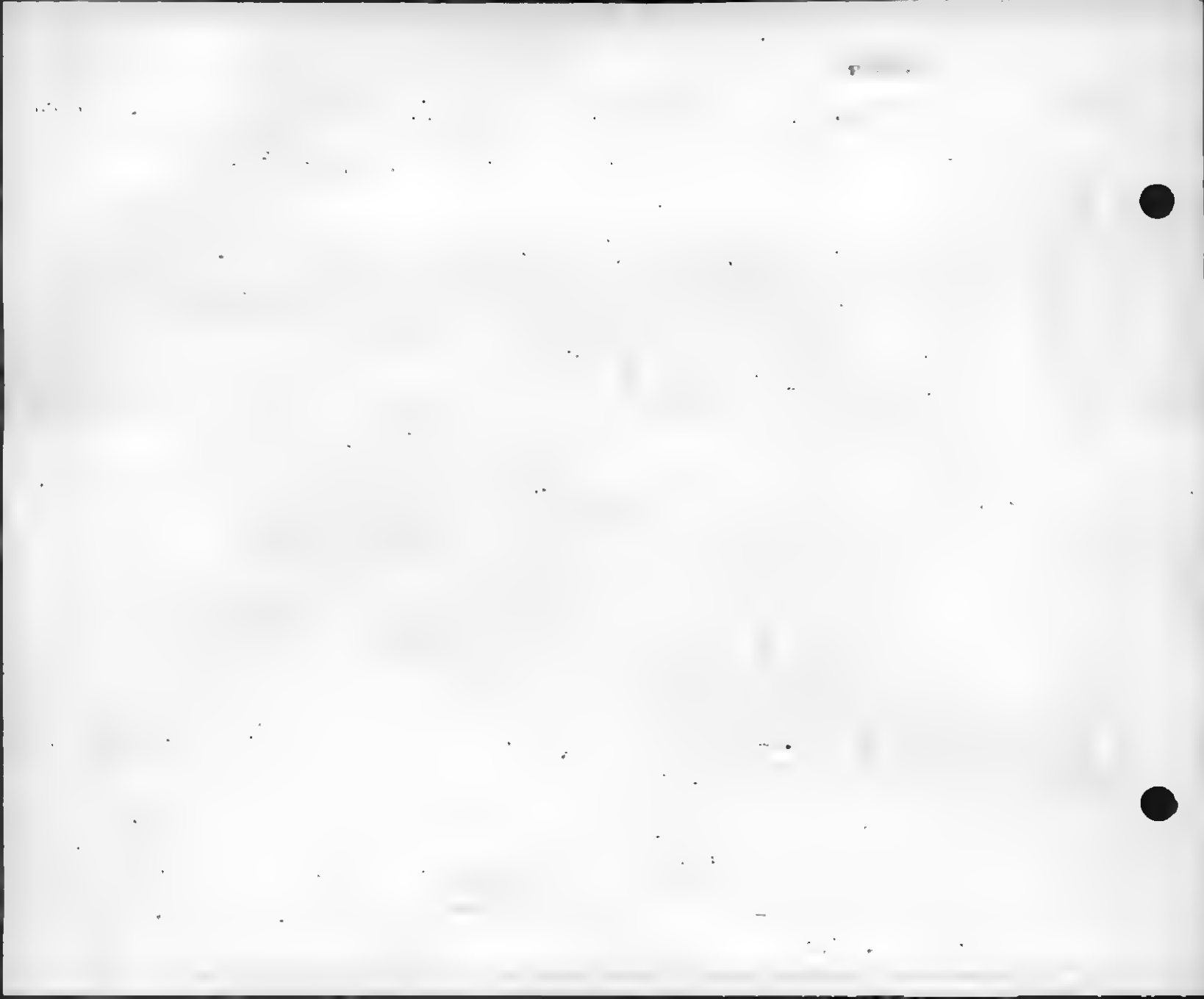


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First <i>Helen</i> Middle <i>Kennard</i> Last <i>Chapman</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>18</i> Year <i>1968</i>			2b. HOUR <i>10:20 PM</i>	
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH <i>Feb 9 1886</i>		6 AGE (In years lost birthday) <i>82</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Prince George</i> Md	
10 CITY OR TOWN OF DEATH <i>Hyattsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hyattsville Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>WASH DC</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <i>Hunter</i> Middle <i>Kennard</i> Last <i>Gill</i>		15. MOTHER'S MAIDEN NAME First <i>HONORAH</i> Middle <i>Gill</i> Last <i>Gill</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>370-32-4272</i>		17. INFORMANT <i>LOIS HOUGHTON</i>		Address <i>3173 PORTER ST DC</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASHD</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiomyopathy</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4.00 months of CVA's Cachexia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 19 64</i> , to <i>3/18 1968</i> , that (I) (we) last saw the deceased alive on <i>3/18 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. H. Sandstrom MD</i>				22c. DATE SIGNED <i>3/18/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom MD</i>				22e. ADDRESS <i>770 Carroll Ave Takoma Park, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-22-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grand Lawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Detroit, Mich.</i>	
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm</i>				ADDRESS <i>4308 Suitland Road Suitland Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 21 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/66

Item 13 Film G399

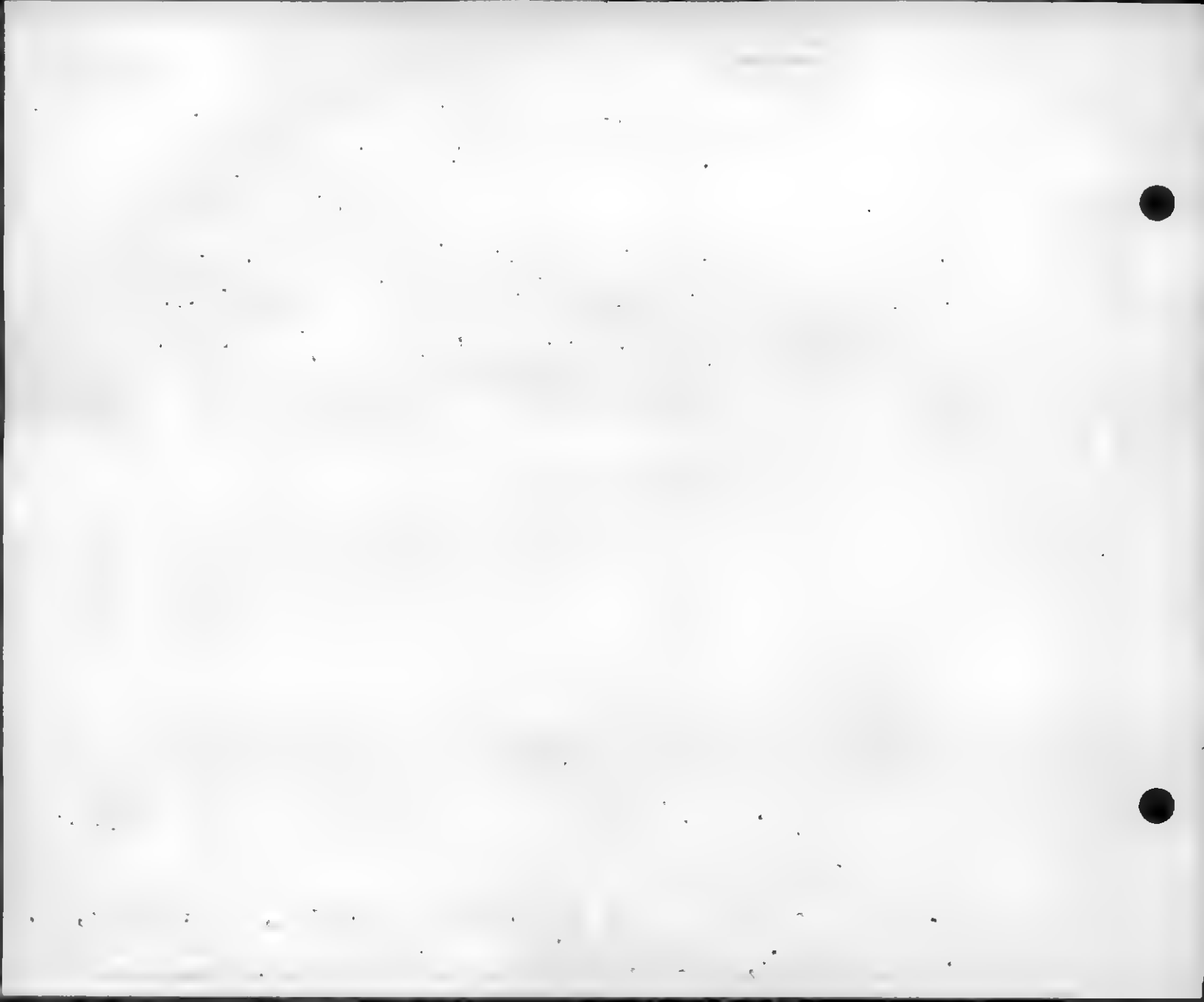
4/1/68 kk 54545

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14530

1 DECEASED NAME (Type or print) First Middle Last <u>Tessie Chiozewski Chy</u>			2a DATE OF DEATH Month Day Year <u>3</u> <u>20</u> <u>68</u>			2b HOUR <u>3 AM</u>				
3 SEX <u>F</u>		4 RACE <u>W</u>		5 DATE OF BIRTH <u>9/20/89</u>		6 AGE (In years last birthday) <u>78</u> YRS.		7 UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <u>Poland</u>		7b CITIZEN OF WHAT COUNTRY? <u>US</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>PRINCE GEORGE</u> Md				
10 CITY OR TOWN OF DEATH <u>Clinton</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>PINEVIEW GARDENS</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Seamstress</u>			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>WASH. D.C.</u>			13b COUNTY <u>PRINCE GEORGE</u>			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER <u>2807 Erie St. SE</u> <u>STUARTVILLE</u>	
14 FATHER'S NAME <u>William</u> <u>MARCE</u>			Middle Last <u>PANKOWSKI</u>			15 MOTHER'S MAIDEN NAME First Middle Last <u>ANNA</u> <u>PRUSZINSKA</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <u>372-03-34525A</u>			17 INFORMANT <u>DAUGHTER</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLAPSE</u> <u>1124</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PRE RENAL UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>42</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>68</u> , to <u>3/20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Alfred R Latin</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3-20-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>ALFRED R LATIN</u>						22e. ADDRESS <u>CLINTON, MD</u>				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b DATE <u>3/22/68</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d LOCATION (City or Town) (County) (State) <u>Suitland, Prince Georges, Md.</u>		
24 FUNERAL DIRECTOR <u>Robert E. Wilhelm</u> <u>4308 Suitland Road, Suitland, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 21 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

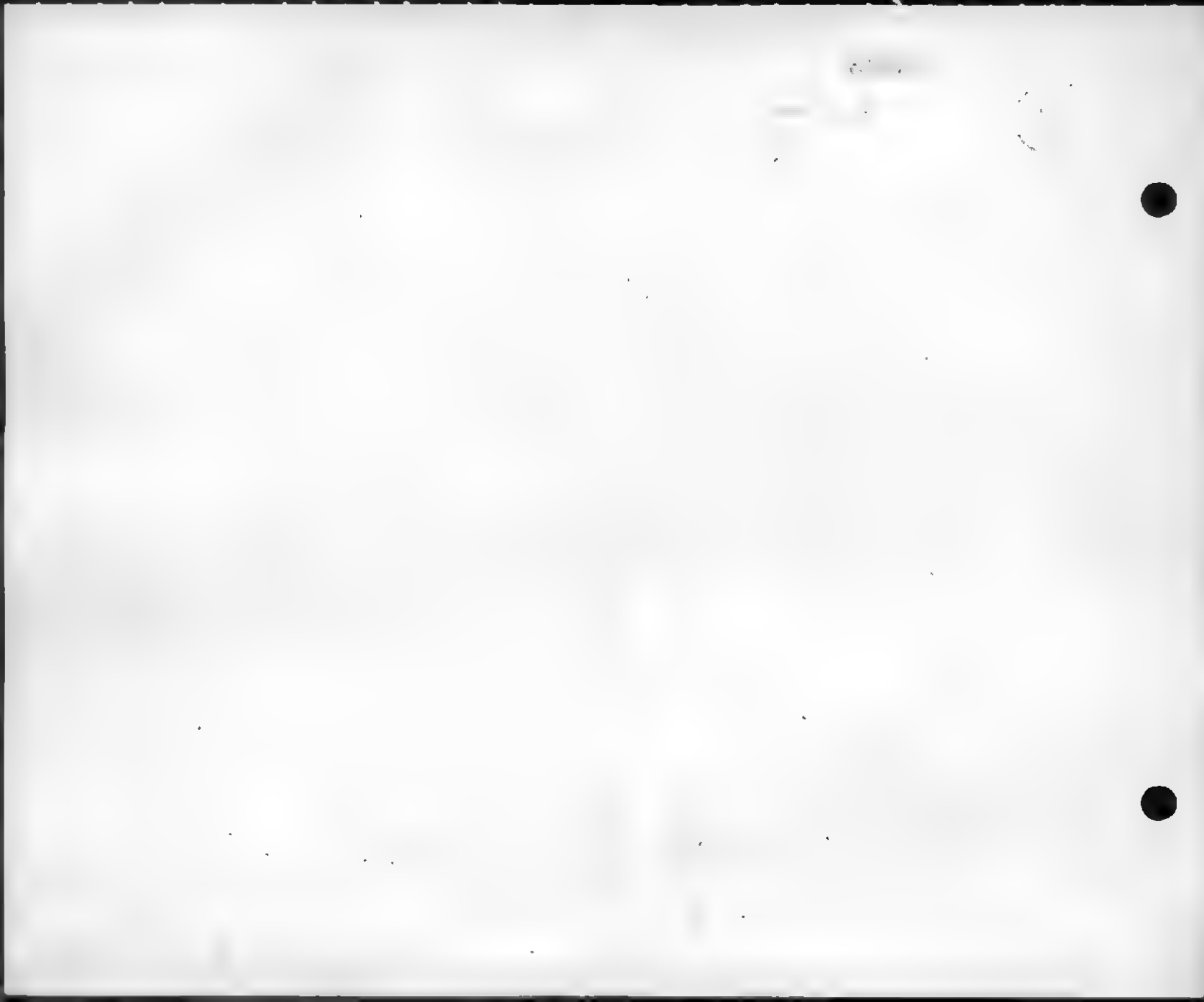
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER:

VR A15ME  
10M REV 7

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		KNOWN <input type="checkbox"/> ESTI- MATED <input type="checkbox"/>		Month		Day		Year		2b. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year					
M		W		June 22 1938		44 YRS		MONTHS		DAYS		HO. HRS		MIN		March 28		1968					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH											
Maryland				USA								Prince Georges											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b. KIND OF BUSINESS OR INDUSTRY											
Bladensburg								Child															
13a. USUAL RESIDENCE (Where deceased lived, if not institution admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER							
Md				Pr Geo Colmar Manor								YES <input type="checkbox"/> NO <input type="checkbox"/>				4067 Newton St							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT							
First				Middle				Last				First				Middle				Last			
Doyle Hobert Cline sr				Molina, Rita																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
(Yes, no, or unknown)				(If yes give war or dates of service)				Rita Cline				Colmar Manor, Md.											
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned																		few minutes					
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
(b)																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)																							
19a. DATE OF OPERATION																		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)															
				March 68				Subject fell in River															
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No.				City or Town				State							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				River				Near Prince George's Marina				Brentonsburg				Md							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				DAYTON O WATKINS				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				March 29 68							
EXAMINER'S NAME (Type)				DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City or Town, County)							
												Brentonsburg and											
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)				(County) (State)							
Burial				April 1, 1968				Ft Lincoln Cemetery				Colmar Manor Pro Geo Md.											
24. FUNERAL DIRECTOR										25a. REC'D BY REG STRAR				25b. REG STRAR'S SIGNATURE									
F. Gasch's Sons Hyattsville, Md.										APR 1 - 1968				Charles Judge									



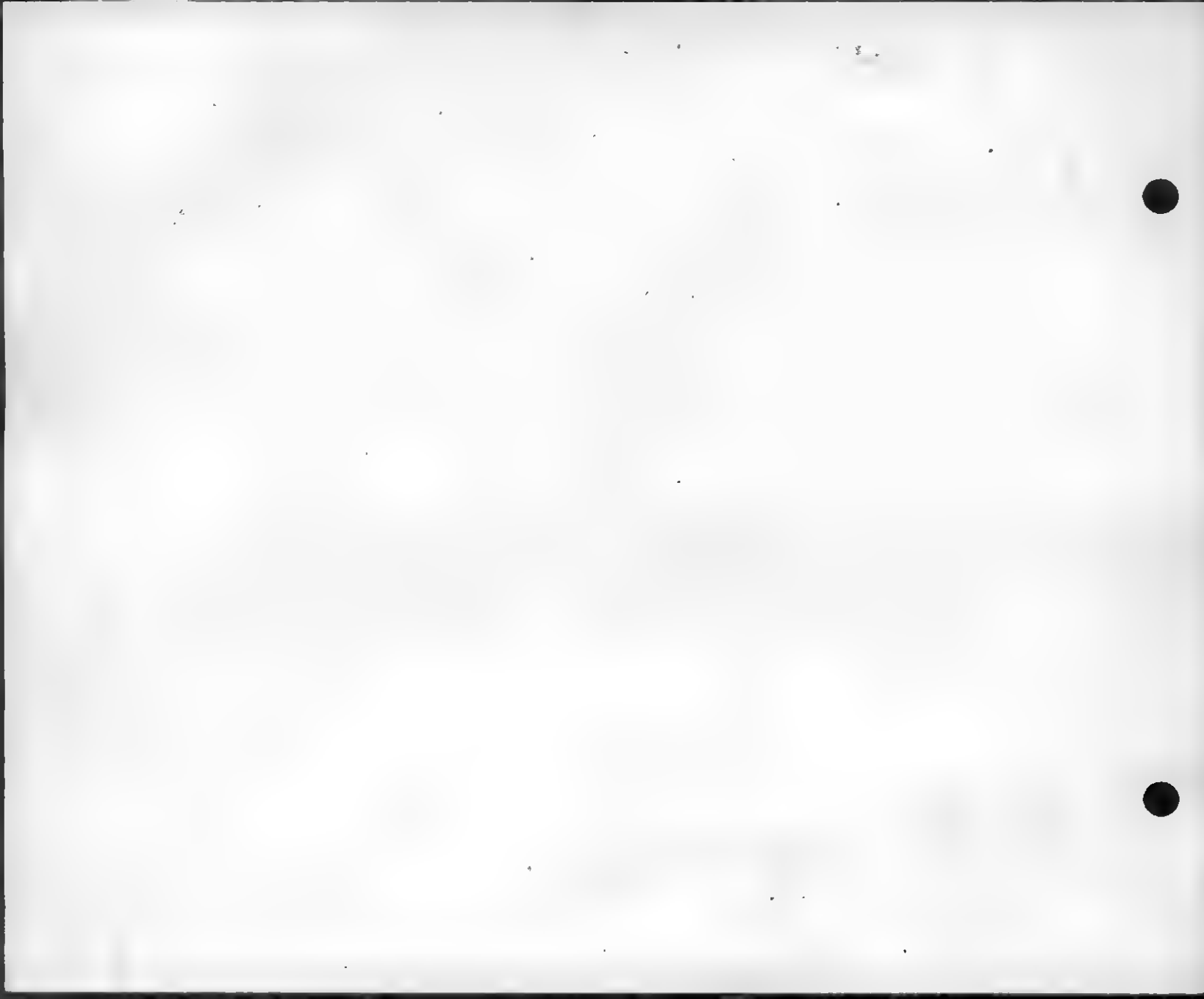
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) Steven Eugene Coddington		First Middle Last		2a DATE KNOWN OF DEATH MATED 3 8 68 19 15am		2b HOUR	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 2-4-68	6 AGE (In years last birthday) YRS 14 MONTHS 14 DAYS 14 HOURS MIN	2c DATE PRONOUNCED DEAD Month 3 Day 8 Year 68 19 2:30am		2d HOUR	
7a BIRTHPLACE (State or foreign country) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Gen. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b KIND OF BUSINESS OR INDUSTRY none	
13a USUAL RESIDENCE (Where deceased lived, if instituting a Residence before admission) - STATE Maryland		13b CITY OR TOWN Forestville		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7917 Penna. Ave.	
14 FATHER'S NAME David Coddington		First Middle Last		15 MOTHER'S MAIDEN NAME Ruby Turner		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO none		17 INFORMANT David Coddington 7917 Penna. Ext.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute interstitial pneumonitis 484X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SDII DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7630							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD		22b. DATE SIGNED 3-8-68		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/10/68		23c NAME OF CEMETERY OR CREMATORY Steele Cemetery		23d LOCATION (City or Town) (County) (State) Friendsville, Md.	
24 FUNERAL DIRECTOR Gerald N. Minnick		ADDRESS Oakland, Maryland		25a REC'D BY REGISTRAR MAR 13 1968		25b REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

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VR A15 (4)  
30M REV 1/68

MD548

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Baby Boy Collins</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>9A.</b> M			
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>March 12, 1968</b>		6. AGE (In years lost birthday) YRS. MONTHS DAYS <b>22 19</b>		7. UNDER 1 YEAR MONTHS DAYS <b>22 19</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LMA 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>57 I Ridge Rd.</b>	
14. FATHER'S NAME First <b>Delbert L. Collins</b> Middle <b>Teresa</b> Last <b>Ann Slack</b>			15. MOTHER'S MAIDEN NAME First <b>Teresa</b> Middle <b>Ann</b> Last <b>Slack</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Atelectasis, bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1776.2</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory Distress Syndrome (clinical)</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>March 12, 1968</b> to <b>March 13, 1968</b> , that (I) <del>we</del> lost saw the deceased alive on <b>March 13, 1968</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>(did not)</del> view the body after death									
22b. SIGNATURE <b>Bernardo Alvarado, M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>March 14, 1968</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>6201 Riverdale Road, Riverdale, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>3/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. General Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Maryland</b>			
24. FUNERAL DIRECTOR <b>William A. Parker, Assoc. Administrator</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

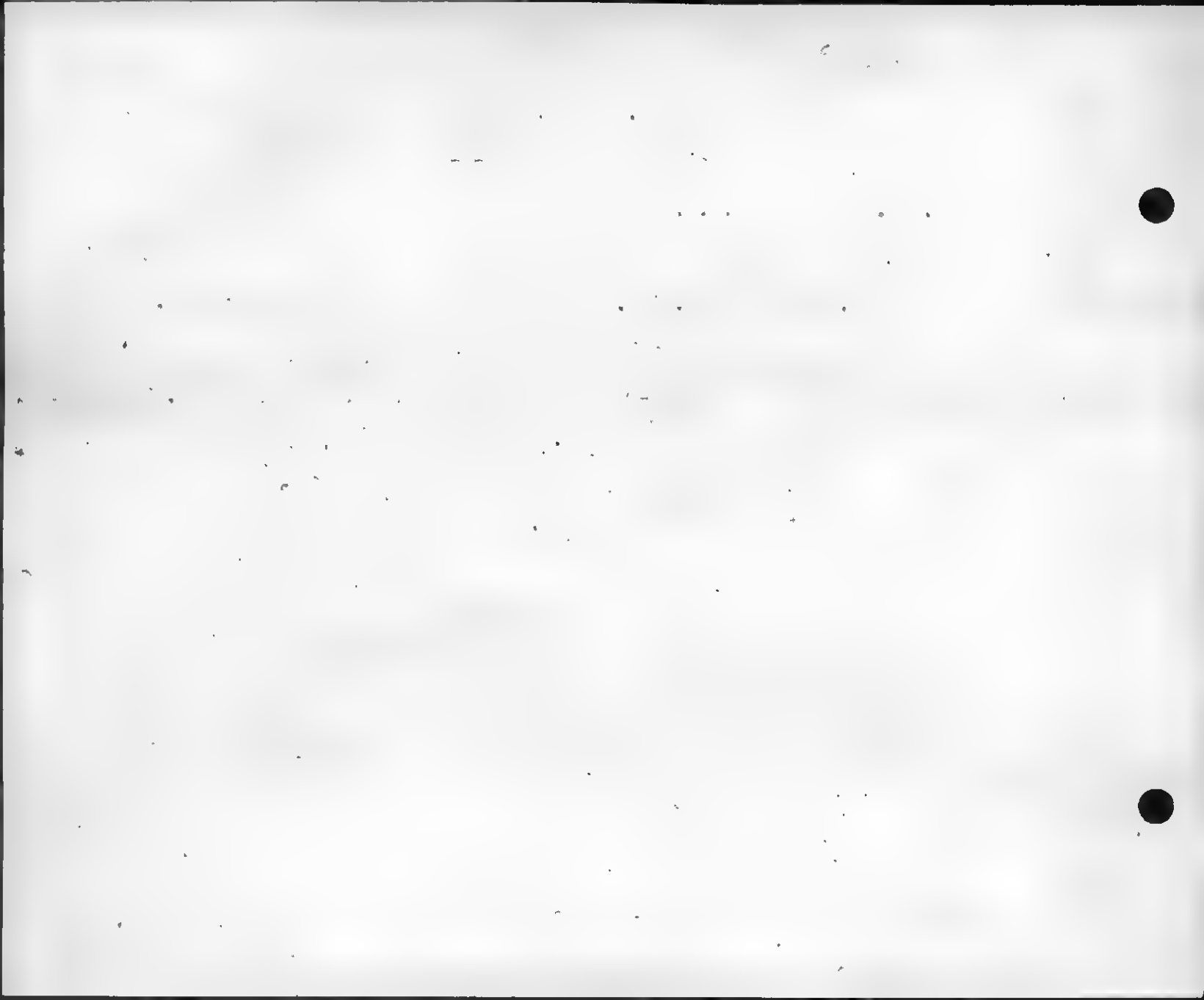
1967, October 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Pearl E. Collins</b>			2a. DATE OF DEATH Month Day Year <b>March 4 1968</b>			2b. HOUR P <b>1:25M</b>	
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4-3-89</b>		6. AGE (In years lost birthday) <b>78</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Geo.</b> Md	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Gardens</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Suitland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>3701 Summer Rd.</b>		14. FATHER'S NAME First Middle Last <b>Judson Sisler</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Blosser</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>178-07-3647</b>		17. INFORMANT <b>Frank Swaney</b>		Address <b>3701 Summer Rd. Suitland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest collapse</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary infarction</b> (b) <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerosis generalized. Left hip pin</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>3 days</b> <b>2 yrs.</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-31-1968</b> , to <b>3-4-1968</b> , that (I) (we) last saw the deceased alive on <b>3-4-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alfred R. Lapin, M.D.</b>						22c. DATE SIGNED <b>3/4/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPIN, M.D.</b>						22e. ADDRESS <b>CLINTON, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/8/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithfield Baptist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Smithfield, Penna.</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road Suitland Maryland</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

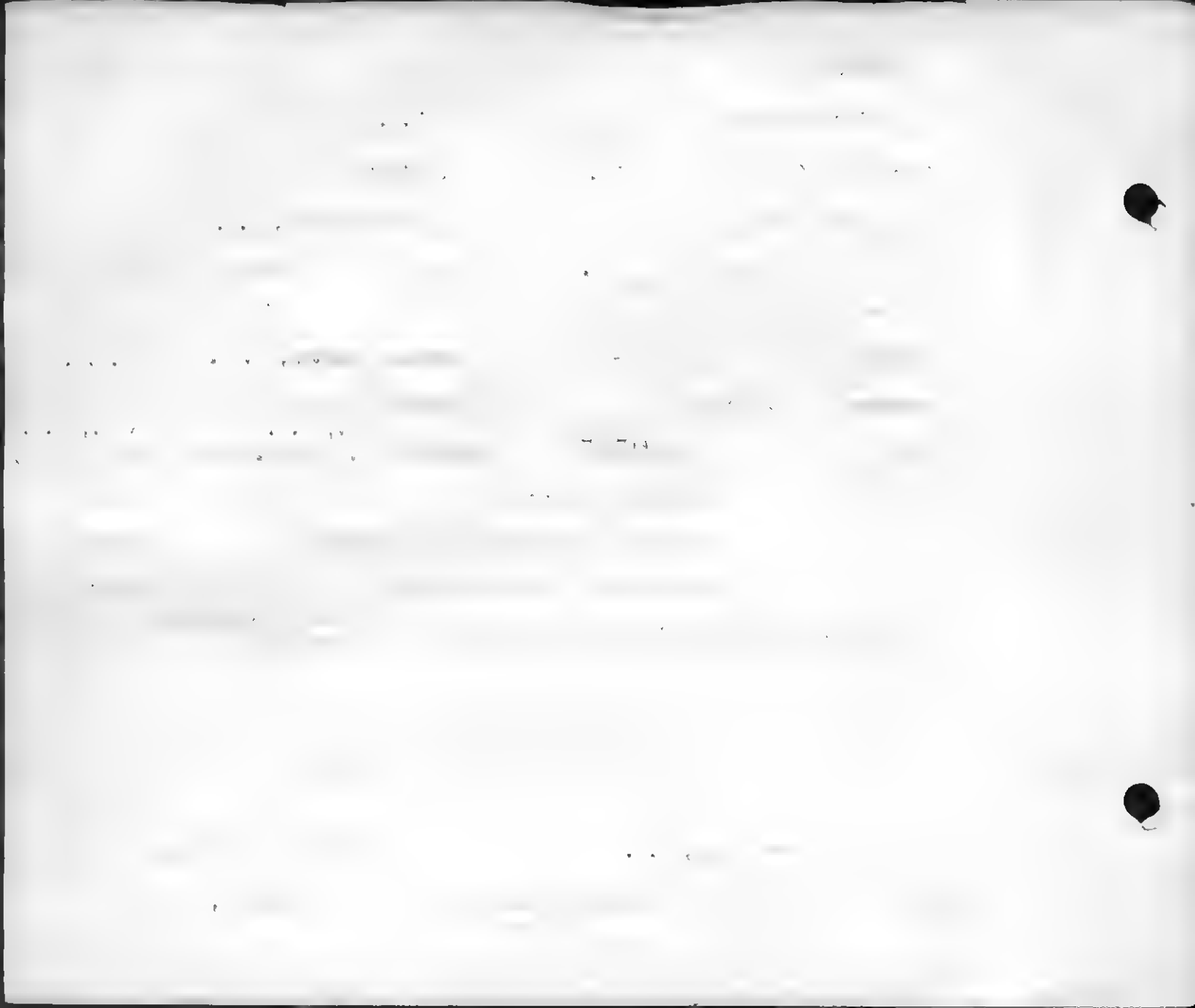


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>D.C.</b> b COUNTY <b>✓</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c LENGTH OF STAY IN b <b>1 Yr. 8 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1242 5th Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Huges</b> Middle <b>T.</b> Last <b>Cottingham</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 68</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/23/1914</b>
9 AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <b>Unknown</b>		10b KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Unknown Polkton, N. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Mack Crump</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Wincy ??</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO <b>577-38-4960</b>	
17 INFORMANT <b>Wash., D.C.</b> Address <b>418 Ost., N.W.</b> <b>(Deceased) Mr. Odes W. Cottingham (husband)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary arteriosclerotic disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b> <b>Unknown</b> <b>Unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular accident, with right cerebral infarction, old; chronic pyelonephritis; bilateral hydronephrosis; left renal calculus</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that <b>(X)</b> (this hospital) attended the deceased from <b>3/3/</b> , 19 <b>67</b> , to <b>3/11/</b> , 19 <b>68</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>3/11/</b> , 19 <b>68</b> , and that death occurred at <b>1:55A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>3/11/1968</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-16-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Landover, Maryland</b>
24. FUNERAL DIRECTOR <b>Malvawt Selkey Inc.</b>		25a. REC'D BY REGISTRAR <b>424-2222</b>	
25b. REGISTRAR'S SIGNATURE <b>Washington D.C.</b>		DATE <b>MAR 15 1968</b>	

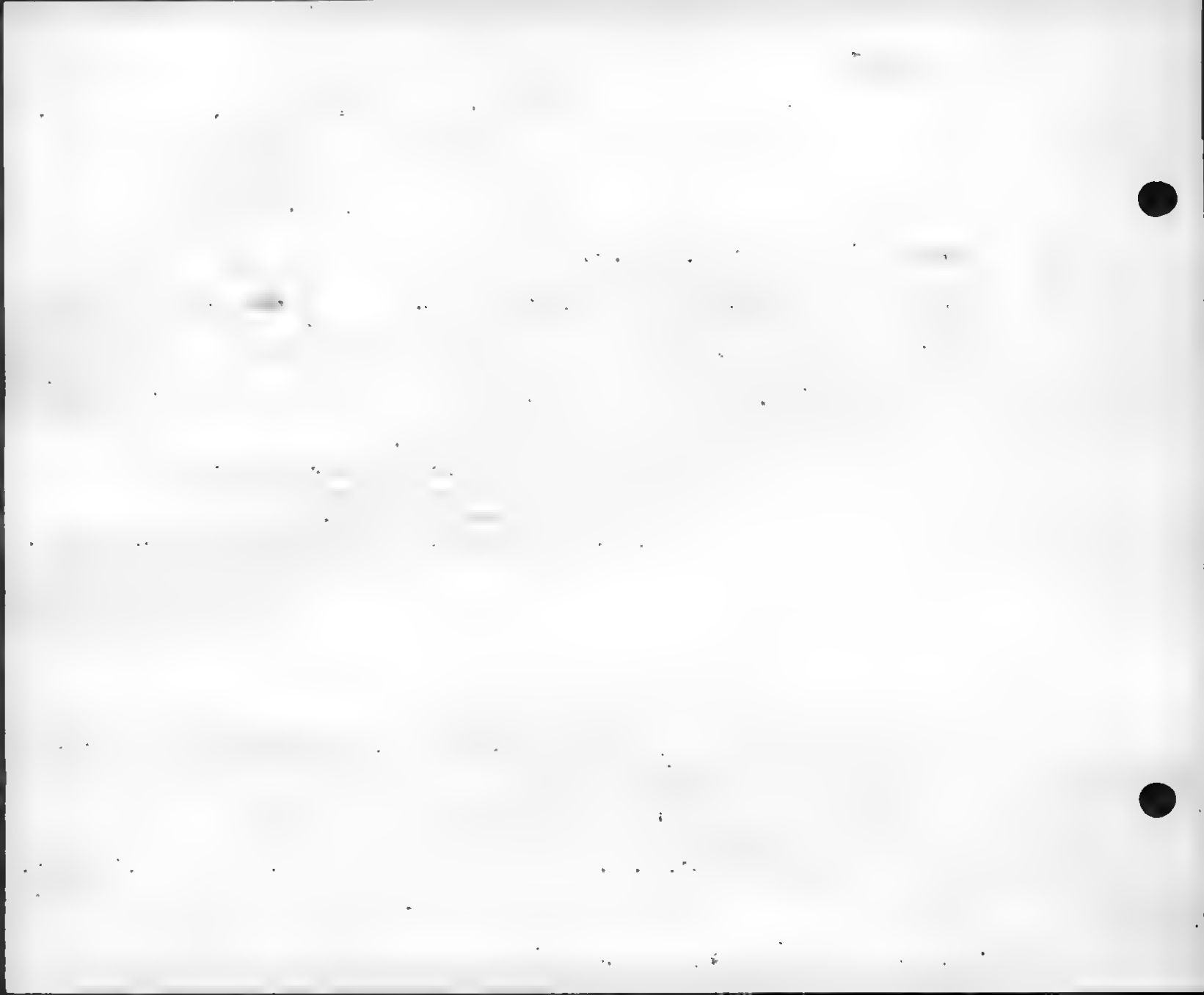
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)		First Middle Last		2a. DATE OF DEATH			2b. HOUR		
Mary Covington				March 21, 1968			2 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday) YRS.		
Female		Negroid		10/25/68 1895			72		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
D.C.		U.S.A.				Prince Georges		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince Geo. Gen'l Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Prince Georges		Fairmont Hgts.		911 60th Avenue			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Harrison Sneed		Mary Fletcher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No None		-		Gladys Singleton		911-60th Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho-Pneumonia.  H DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cerebral Arteriosclerosis with Thrombosis of the Basilar artery and the right middle cerebral artery. DUE TO, OR AS A CONSEQUENCE OF (c) Infarction of the right occipital lobe and right cerebellum. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 6, 1968, to March 21, 1968, that (I) (we) lost saw the deceased alive on March 21, 1968, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Edwin Jensen MD		13/21/68		Edwin Jensen, M. D.					
22e. ADDRESS		22f. REC'D BY REGISTRAR							
Prince Georges General Hospital, Cheverly,		DATE 27 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)			
3-26-68		Sneed Grove		Elkbee N.C.			Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE			
H.S. Washburn & Son		4525 Penn		Charles Judge					



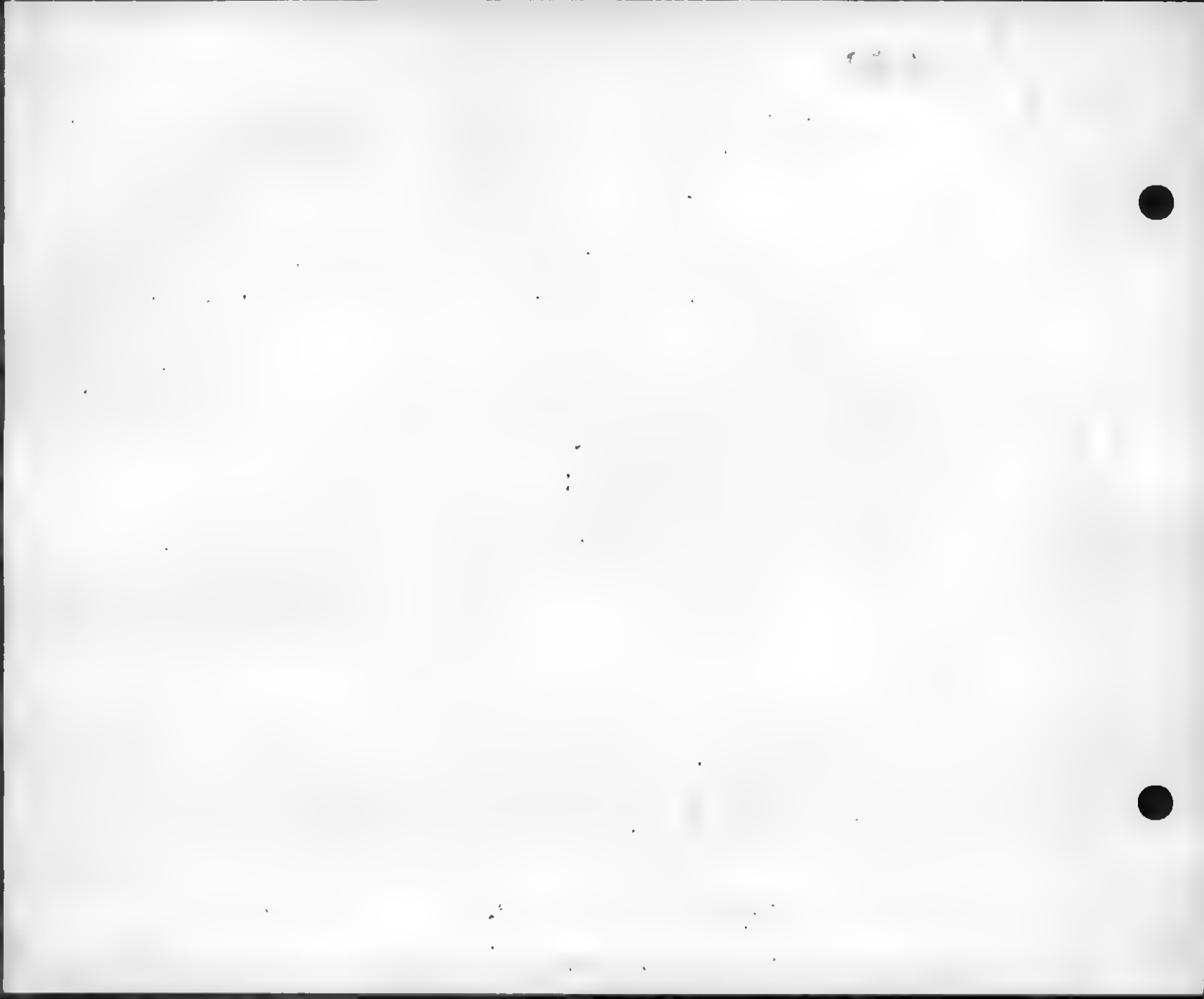


## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <u>Lillian</u> First <u>Y.</u> Middle <u>Cross</u> Last			2a. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1968</u>			2b. HOUR <u>11:33</u> M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>7-20-1890</u>		6. AGE (In years last birthday) <u>77</u> YRS		IF UNDER 1 YEAR MONTHS <u>7</u> DAYS <u>26</u>		IF UNDER 24 HRS HOURS <u>11</u> MIN.	
7a. BIRTHPLACE (State or foreign country) <u>DC</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>PRINCE GEORGES MD</u>					
10. CITY OR TOWN OF DEATH <u>FORESTVILLE</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>THE REGENT</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red) <u>HOUSEWIFE</u>			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>D.C.</u>			13b. COUNTY <u>—</u>			13c. CITY OR TOWN <u>WASHINGTON</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>2427 Monroe St. N. E.</u>	
14. FATHER'S NAME First <u>—</u> Middle <u>—</u> Last <u>WOOD</u>			15. MOTHER'S MAIDEN NAME First <u>—</u> Middle <u>—</u> Last <u>—</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		
17. INFORMANT <u>LILLIAN YOBST-5531 St. BARBARAS RD</u>			Address <u>Oxon Hill, MD</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1870</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Right renal</u> (c) <u>carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>1870</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1870x</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u> <u>13 years</u>		
19a. DATE OF OPERATION <u>2/5/68</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			21g. LOCATION (City or Town) (County) (State)		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> , 19 <u>68</u> , to <u>3/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Frederick H. Wilhelm</u>			22c. DATE SIGNED <u>3/10/68</u>			22d. PHYSICIAN'S NAME (Type) <u>634 Landon Road, Chevy Chase, Maryland</u>			22e. ADDRESS		
23a. BURIAL CREMATION, REMOVAL (Specify) <u>cremation</u>			23b. DATE <u>3/13/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			23d. LOCATION (City or Town) (County) (State) <u>Smithland, Md.</u>		
24. FUNERAL DIRECTOR <u>James T. Ryan Inc</u>			ADDRESS <u>315 Penn Ave</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 13 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



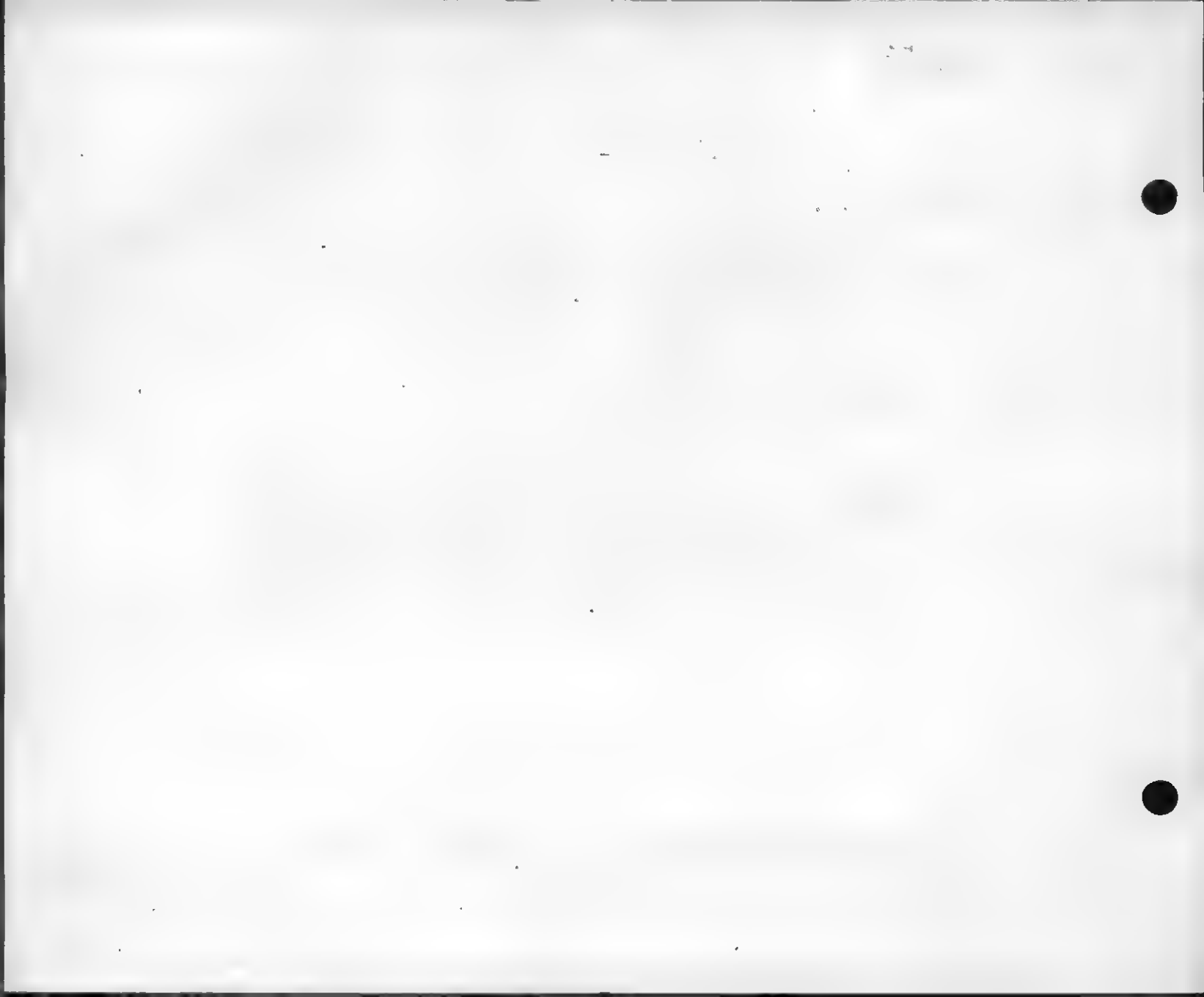
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) John Dominic Crovo			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-9-68 MATED <input type="checkbox"/> 3-9-68			2b. HOUR 193:00am		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 1-15-1916 <del>1-17-1913</del>	6 AGE (In years last birthday) 52 YRS	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3 Day 9 Year 68 193:39am		
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Grocery		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before) Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Mt. Rainier		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4621 Eastern Avenue
14. FATHER'S NAME Dominic D. Crovo			15. MOTHER'S MAIDEN NAME Estelle -- Elliott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT 5803 Quabac Street John E. Crovo Berwyn Hts, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe MD			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3-10-68
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-12-1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md.		
24. FUNERAL DIRECTOR Nalley Funeral Home Mt. Rainier, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...

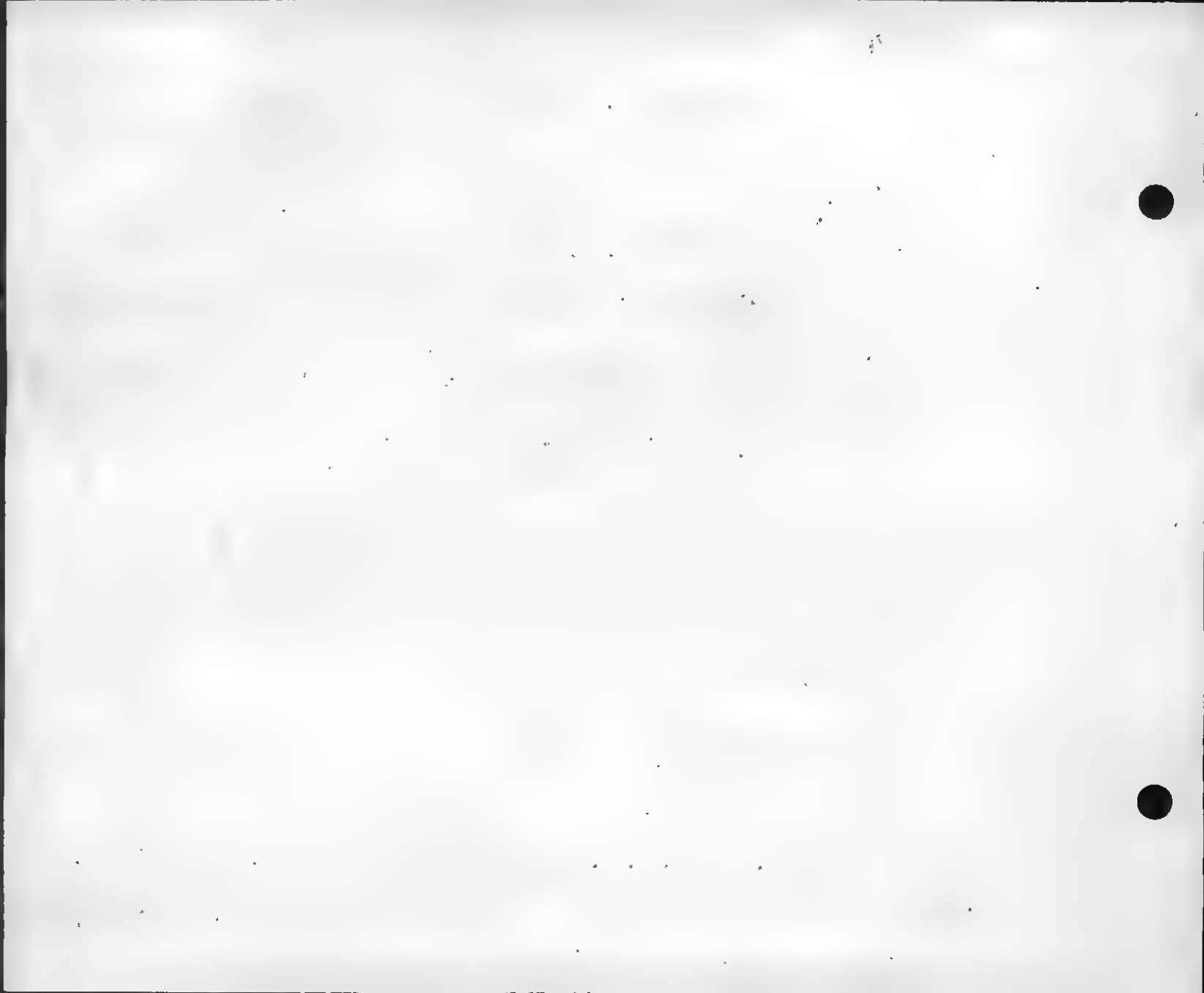


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VR A 5 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Elizabeth Middle W. Last Daugherty			2a. DATE OF DEATH Month March Day 10, Year 1968			2b. HOUR 8:05 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 5/27/1907			6. AGE (In years last birthday) 60 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md					
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Clerk			12b. KIND OF BUSINESS OR INDUSTRY Shoe Stores		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Georges			13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4401 Queensberry Road	
14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 249-40 6325			17. INFORMANT F. DREXEL DAUGHERTY			Address Same AS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the head of the Pancreas with DUE TO, OR AS A CONSEQUENCE OF widespread metastasis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 15											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to March 10, 1968, that (I) (we) last saw the deceased alive on March 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul A. DeVore								DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Paul A. DeVore, M. D.				22e. ADDRESS 3415 Hamilton St. W. Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 14 March 1968		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City or Town) Suitland		(County) Maryland		(State)	
24. FUNERAL DIRECTOR W. W. Chambers Co Riverdale, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 15 1968		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

VR 10-5-64  
30M REV. 1-7-68

02555

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04549

1. DECEASED-NAME (Type or print) Baby Girl Davis			2a. DATE OF DEATH Month 24, Day 1968 Year 6:55A M			
3. SEX Female		4. RACE Negroid		5. DATE OF BIRTH March 22, 1968		
7a. BIRTHPLACE (State or foreign country) Cheverly		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5009 46th Avenue				
14. FATHER'S NAME First Middle Last Rudolph Edward Davis			15. MOTHER'S MAIDEN NAME First Middle Last Mary Kay Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mother		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>prematurity</u> 1050 GMS. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary atelectasis bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)				
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>March 22, 1968</u> , to <u>March 24, 1968</u> , that <del>the</del> (we) lost saw the deceased alive on <u>March 24, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Bernardo Alvarado</i>				22c. DATE SIGNED 3/26/68		
22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.				22e. ADDRESS Prince Georges General Hospital, Cheverly, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) 4/6/68		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Prince Geo Gen. Hospital		
23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland		23e. NAME OF CEMETERY OR CREMATORY				
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATE





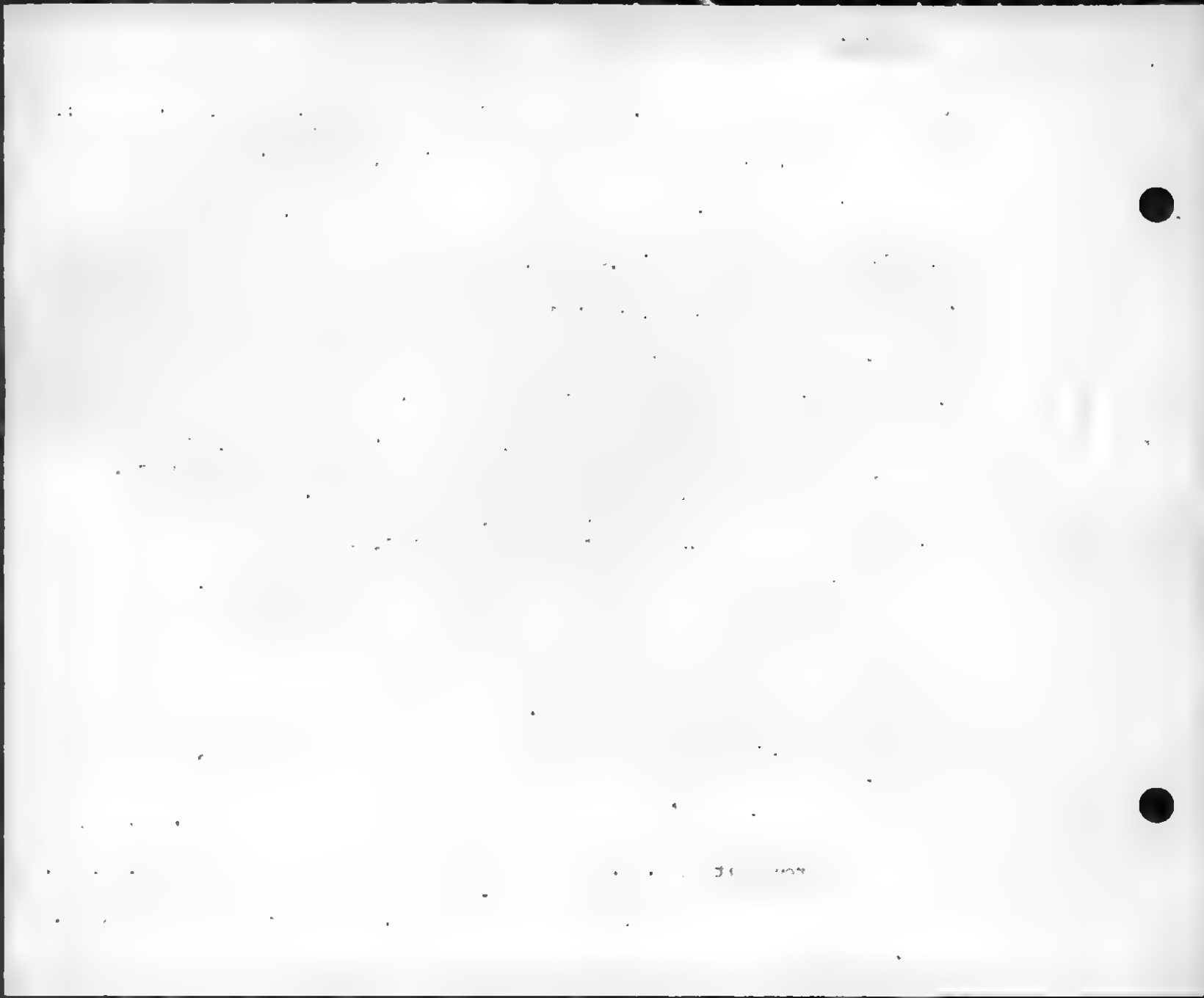
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4556  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

345.11

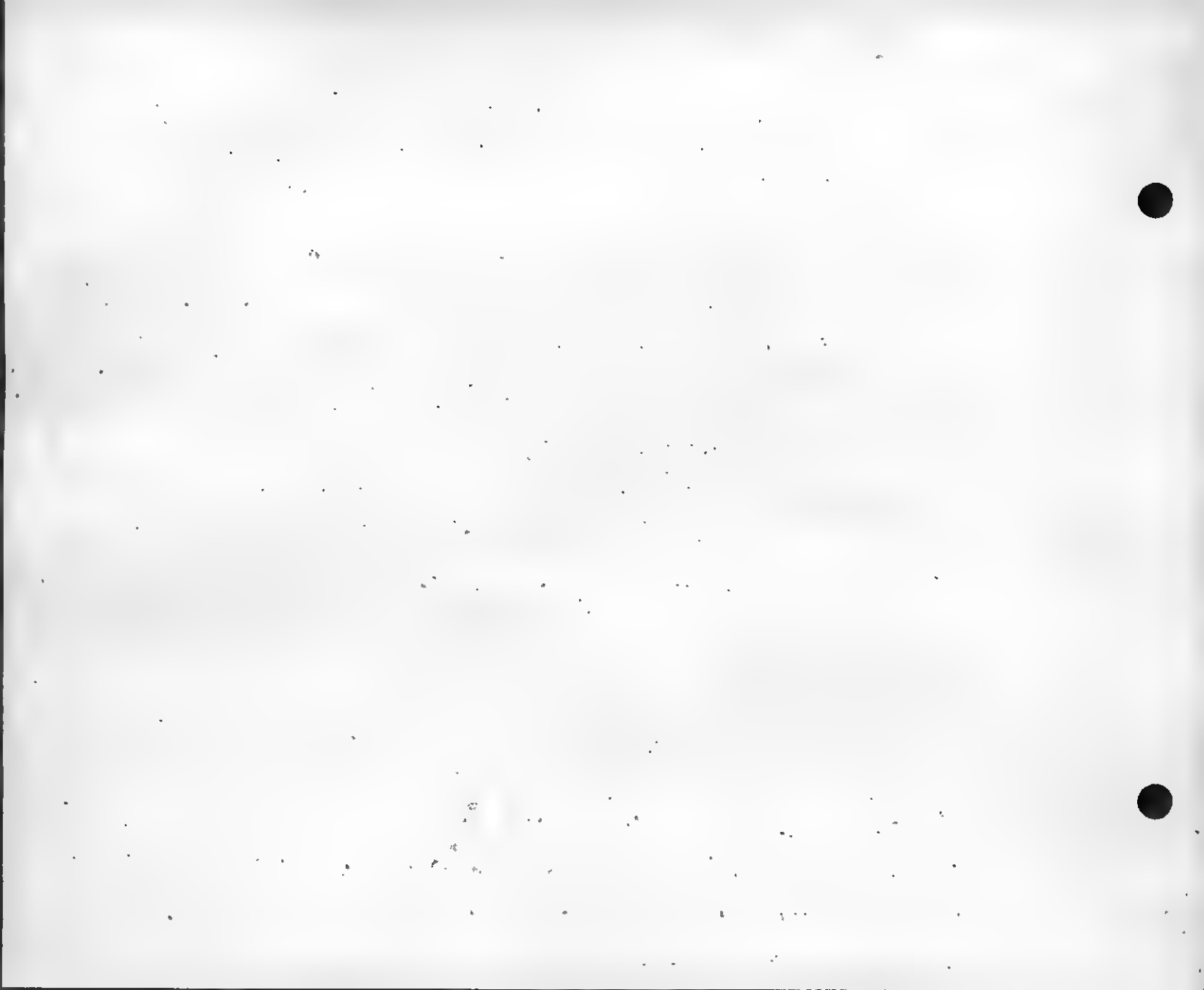
1. DECEASED-NAME (Type or print) <b>Kyle</b>		First <b>W.</b>		Middle <b>Dean</b>		Last <b>Dean</b>		2a. DATE OF DEATH Month <b>March</b> Day <b>21</b> , Year <b>1968</b>		2b. HOUR <b>9:10 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>August 23, 1915</b>		6. AGE (In years last birthday) <b>52</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INS. OF CITY L.M.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4703 68th Place</b>			
14. FATHER'S NAME <b>IRVIN</b>		First <b>BEAN</b>		Middle <b>NOLA</b>		Last <b>MANLEY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b>		16b. SOCIAL SECURITY NO. <b>705-14-0483</b>		17. INFORMANT <b>Elizabeth J. Dean</b>		Address <b>Same as above</b>		Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction of the left ventricle with mural thrombus.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thrombosis of right coronary artery.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Infarction of right kidney due to occlusion of right renal artery.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Infarction of the spleen due to thrombosis of the splenic vein.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>March 21, 1968</b> to <b>March 21, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>March 21, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.											
22b. SIGNATURE <b>Aaron Deitz</b>		DEGREE <b>M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>March 22, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M. D.</b>		22e. ADDRESS <b>Prince Georges Plaza, Hyattsville, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Upshur Co. Memorial Park.</b>		23d. LOCATION (City or Town) (County) (State) <b>Buckhannon W. Va.</b>					
24. FUNERAL DIRECTOR <b>F. GASCH'S SONS</b>		ADDRESS <b>HYATTSVILLE, MARYLAND</b>		25a. RECD BY REGISTRAR <b>DATE MAR 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Judge</b>					



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 8

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First		Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Theodore					Detamore	MARCH Month 18 Day 1968 Year		3 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday) YRS		IF UNDER 1 YEAR MONTHS DAYS	
male		white		June 11, 1908		59 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
		U S A				Prince Georges			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Pro Georges Hospital		Carpenter					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Prince Georges		Forrestville		YES <input type="checkbox"/> NO <input type="checkbox"/>		3707 82nd. Street	
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last							
Robert Lee Detamore		Carrie Wisnom							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No				Mrs. Gladys W. Detamore		Forrestville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4/10/67</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u> <u>Immed</u> <u>10 yrs</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Carcinoma of Esophagus Palliative Resection Oct '67</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.)					
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1958, to March 1968, that (I) (we) last saw the deceased alive on March 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/18/68			
<u>KELVIN L. MINCHIN</u>									
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
KELVIN L. MINCHIN		6400 MARLBOROUGH SE WASH DC							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		March 21, 1968		Green Lawn Cemetery		Cambridge, Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<u>Fischer &amp; Son Hyattsville Md.</u>				DATE MAY 20 1968		<u>J. Charles Judge</u>			

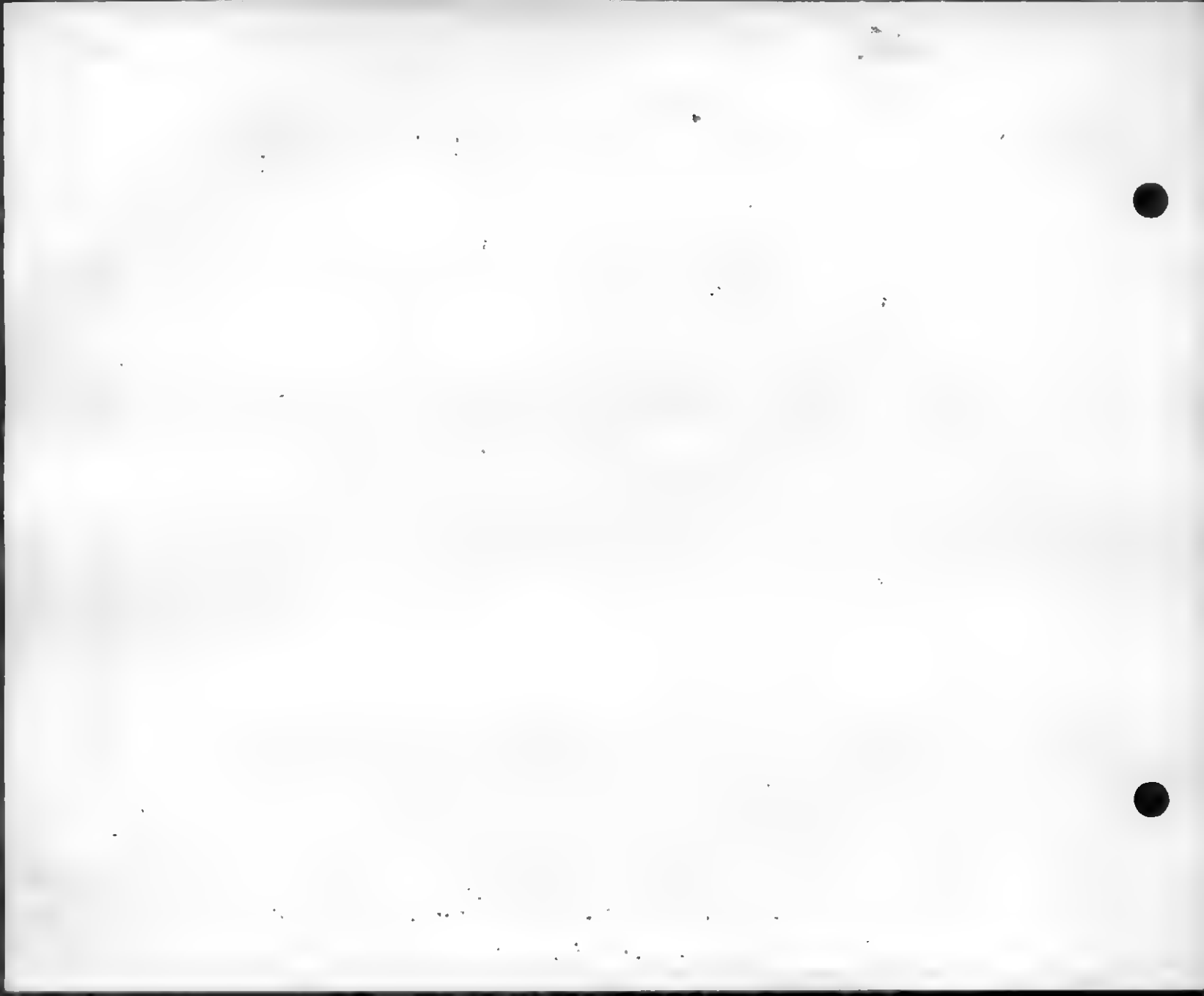


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Alice Annie DeVille</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>2</i> Year <i>68</i>		2b. HOUR <i>12:50</i> M
3 SEX <i>F</i>	4 RACE <i>N</i>	5. DATE OF BIRTH <i>8/5/83</i>		6 AGE (n years last birthday) <i>84</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF JWOER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>MD</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince Georges</i> Md.		
10. CITY OR TOWN OF DEATH <i>Rural</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Upper Marlboro Md.</i>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if ret red)	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>P. George</i>	13c. CITY OR TOWN <i>Rural</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>Unk.</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Unk.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT Address <i>Route-301</i> <i>Mrs. Chantty Curtis Upper Marlboro Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> <i>486X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>493X Diabetes Mellitus</i>					APPROXIMATE INTERVAL - BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>65</i> , to <i>March</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb 28</i> , 19 <i>68</i> , and that (n (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A. Clark Holmes M.D.</i> DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>3/2/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>A. Clark Holmes, M.D.</i>		22e. ADDRESS <i>Upper Marlboro Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>3-5-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection</i>	23d. LOCATION (City or town)	(County)	(State)
24. FUNERAL DIRECTOR <i>Rollins 4339-Hunt Pl NE</i>		25a. REC'D BY REGISTRAR <i>MAR 6 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

64859

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF DEATH				Month	Day	Year	2b. HOUR
Harry A Dixon JR.						3-9-68				19	7	50 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD				Month	Day	Year	2d. HOUR
Male	White	3 Feb. 1946	22 YRS	MONTHS	DAYS	3				9	68	19	7:50 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md			
Md		U S A				Prince George's							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince George Hospital			Mechanic			Automobile				
13a. USUAL RESIDENCE (Where deceased lived 1 institution Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY - A.M. 15?			13e. STREET AND NUMBER				
Maryland			Prince George			Hyattsville			3421 55th. Avenue				
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost		
Harry A Dixon Sr						Edna I Duvall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
yes			220 42 1365			Judith Ann Dixon			Lanham, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO, OR AS A CONSEQUENCE OF <u>Skull fracture</u> (b) <u>From trauma - motorcycle accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>7154</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>4:46 PM 3-9-1968</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Driver of motorcycle involved in collision</u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Rt. 202 and Lottsford Road, Prince George County, Maryland</u>			21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>3-10-68</u>				
John Kehoe MD			Riverdale, Md.			ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			March 13, 1968			Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.				
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE		
F. Gasch's Sons						Hyattsville, Md.			DATE MAR 14 1968		<u>Charles</u>		

11





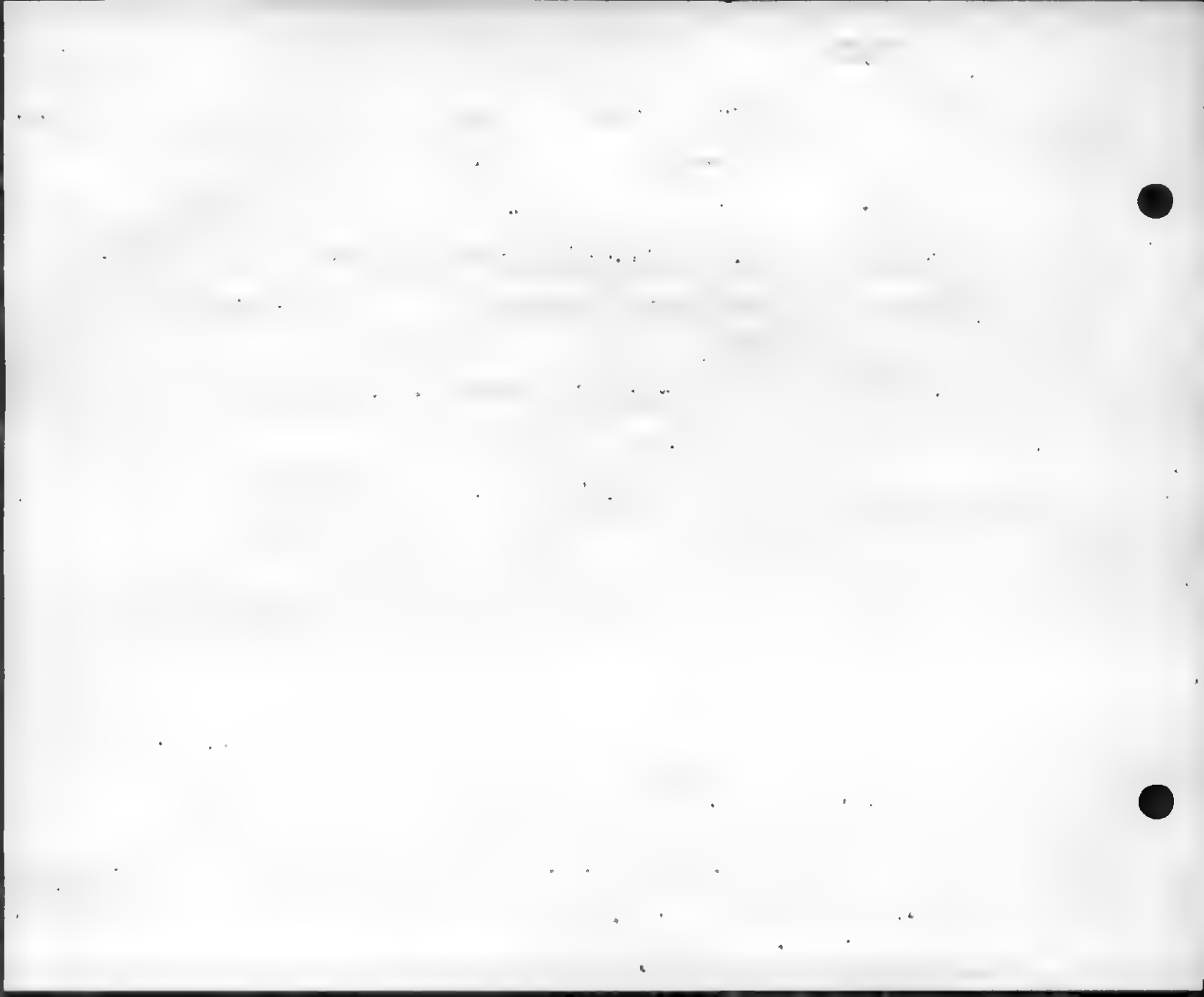
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VR A15 (4)  
30M REV. 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Lawrence Beaver Dolby</b>			2a. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1968</b>		2b. HOUR <b>4 A.M.</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>March 12, 1888</b>		6. AGE (In years last birthday) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Penna.</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Res dence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Morningside</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>306 Boxwood Drive</b>	
14 FATHER'S NAME First Middle Last <b>Joseph Dolby</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Mary Weaver</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>226-44-8340T</b>	17 INFORMANT Address <b>Lawrence B. Dolby Same As 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>5 YEAR</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>March 17, 1968</b> , to <b>March 22, 1968</b> , that <del>we</del> (we) last saw the deceased alive on <b>March 22, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>that</del> (we) (did) <del>not</del> view the body after death.					
22b. SIGNATURE <b>Norman K. Bohrer MD.</b>		DEGREE <input type="checkbox"/> ATTENDING <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>March 22, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Norman K. Bohrer, M. D.</b>		22e. ADDRESS <b>Prince Georges General Hospital, Cheverly,</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/25/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wash. National Cemetery</b>		23d. LOCATION (City or Town) (County) <b>Suitland, Prince Georges, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b>		ADDRESS <b>4308 Suitland Road, Suitland, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 26 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>

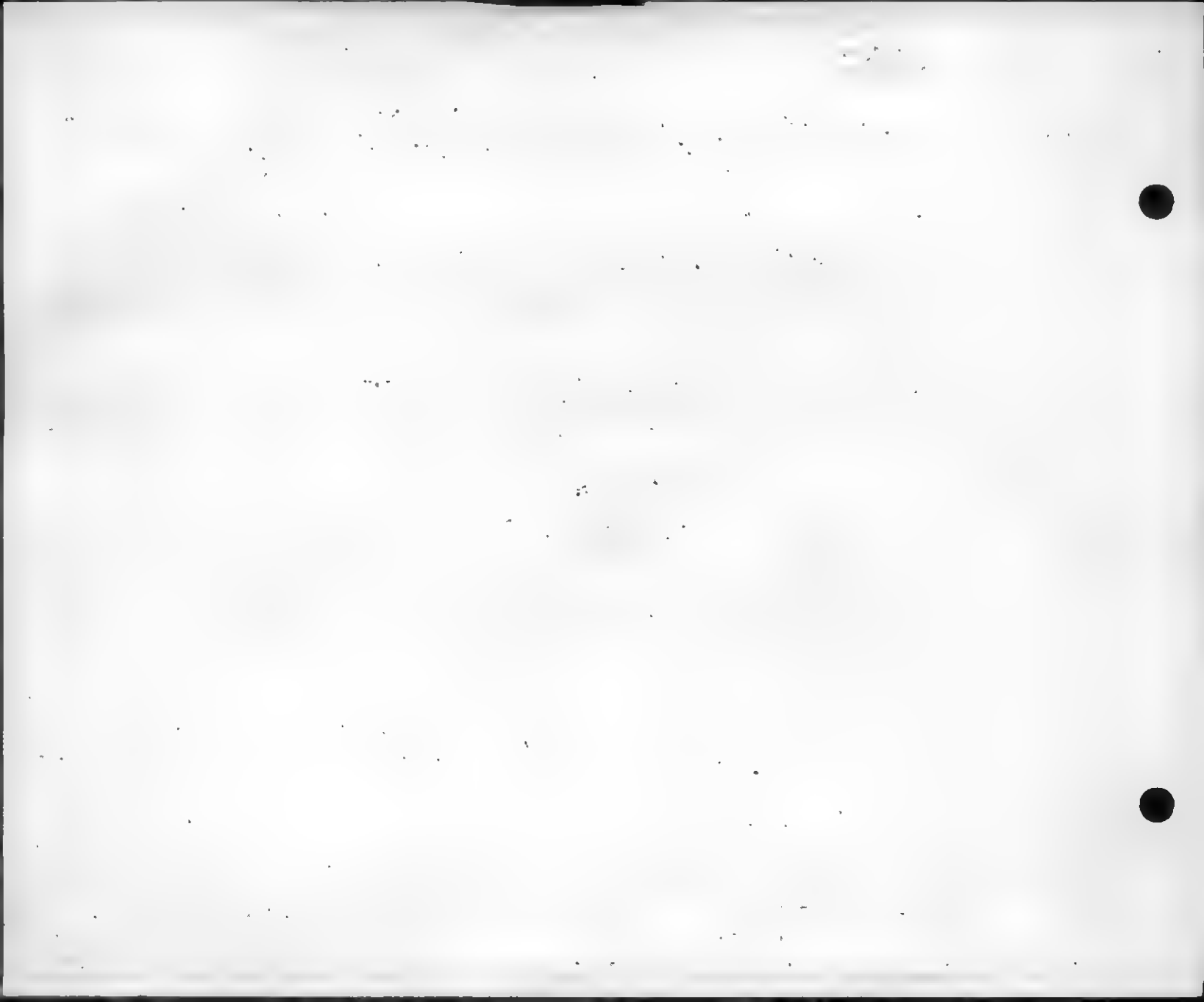


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# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>LILLIAN M DURNBOUGH</b>			2a. DATE OF DEATH Month Day Year <b>3 30 68</b>			2b. HOUR <b>12:5</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>10/15/86</b>		6. AGE (In years last birthday) YRS. MONTHS DAYS <b>81</b>	
7a. BIRTHPLACE (State or foreign country) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>P.G. COUNTY</b>	
10. CITY OR TOWN OF DEATH <b>CLINTON, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PINEVIEW GARDENS</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Forrestville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>213-54-5539</b>		17. INFORMANT <b>DAUGHTER</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL (HEART)</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIO SCLEROSIS.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>YEARS</b> <b>YEARS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>422.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-29</b> 19 <b>67</b> , to <b>3-30</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3-30</b> 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.							
22b. SIGNATURE <b>R. A. LEW</b>		22c. DATE SIGNED <b>3-30-68</b>		22d. PHYSICIAN'S NAME (Type) <b>RALPH LEW, M.D.</b>			
22e. ADDRESS <b>PINEVIEW GARDENS</b>							
23a. BURIAL, CREMATION, REBURY (Type) <b>REBURY</b>		23b. DATE <b>4-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, PG Md.</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>				25a. REC'D BY REGISTRAR <b>APR 3 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

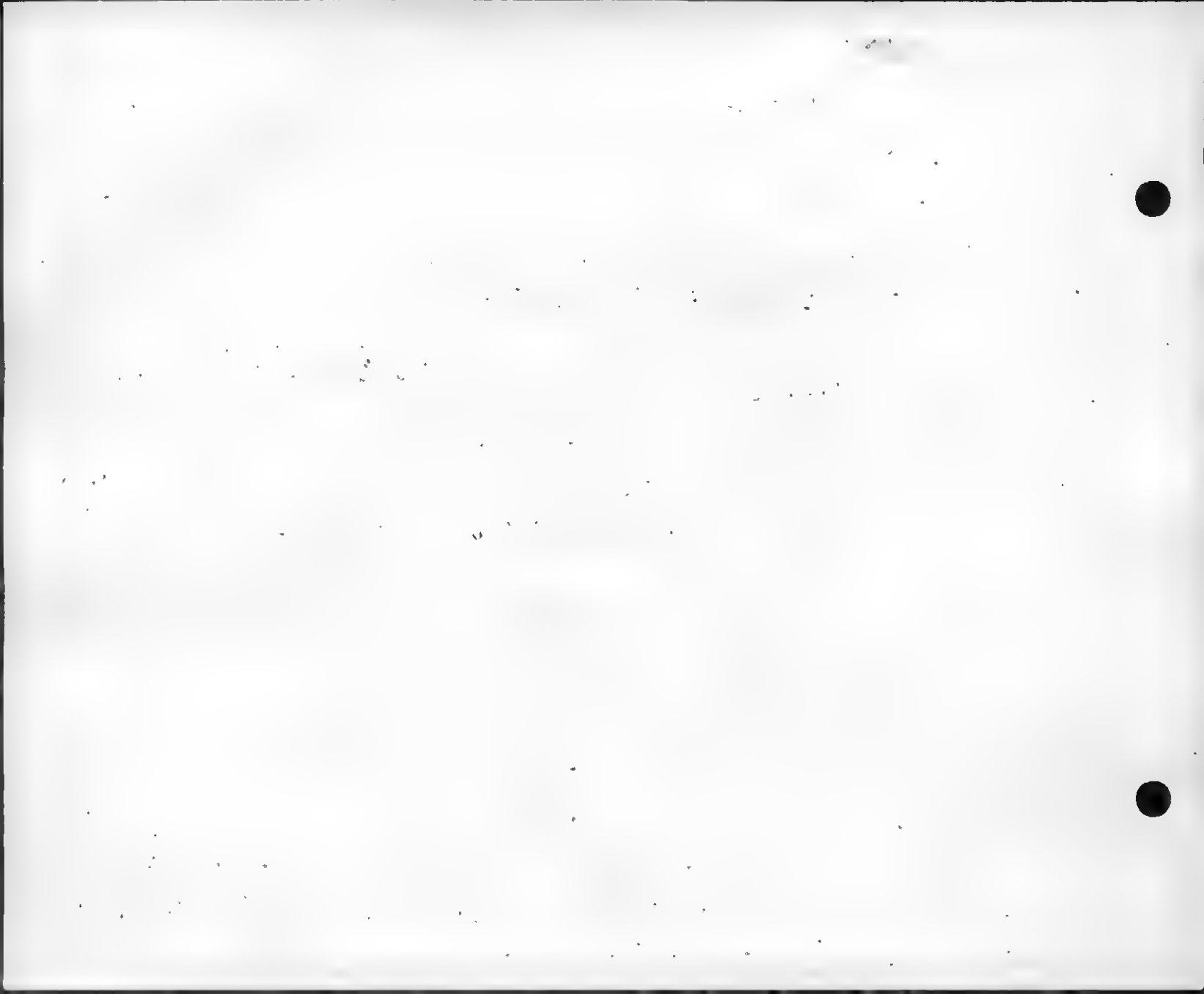
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(M)

MD 62  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

550

1. DECEASED-NAME (Type or print) <b>Cleo James Edwards</b>			2a. DATE OF DEATH Month <b>MARCH</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>11 P M</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>5 MARCH 1895</b>		6. AGE (In years lost birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>NEBRASKA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b> Md.			
10. CITY OR TOWN OF DEATH <b>RIVERDALE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>LELAND MEM HOSPITAL</b>		12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired) <b>GUARD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>PRINCE GEORGE'S</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>4310 40th St.</b>			
14. FATHER'S NAME First Middle Last <b>CHARLES EDWARDS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY M. JONES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (na, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>YES U.S. I</b>		16b. SOCIAL SECURITY NO <b>578240186</b>		17. INFORMANT <b>MRS EDNA M. EDWARDS</b> Address <b>SAME AS #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY VASCULAR SCLEROSIS</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED</b> <b>5 YRS</b> <b>2 YEARS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>7</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , to <b>MARCH, 1968</b> , that (I) (we) last saw the deceased alive on <b>10-27</b> <b>1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Benjamin S. Miller MD</b> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>3-25-68</b> <b>Rainier</b>			
22d. PHYSICIAN'S NAME (Type) <b>Benjamin S. Miller MD</b>				22e. ADDRESS <b>3824 34th St. Mt Rainier</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>26 Mar. 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>COLMAR MANOR, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS &amp; RIVERDALE, MD</b> ADDRESS				25a. REC'D BY REGISTRAR DATE <b>MAR 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John C. Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

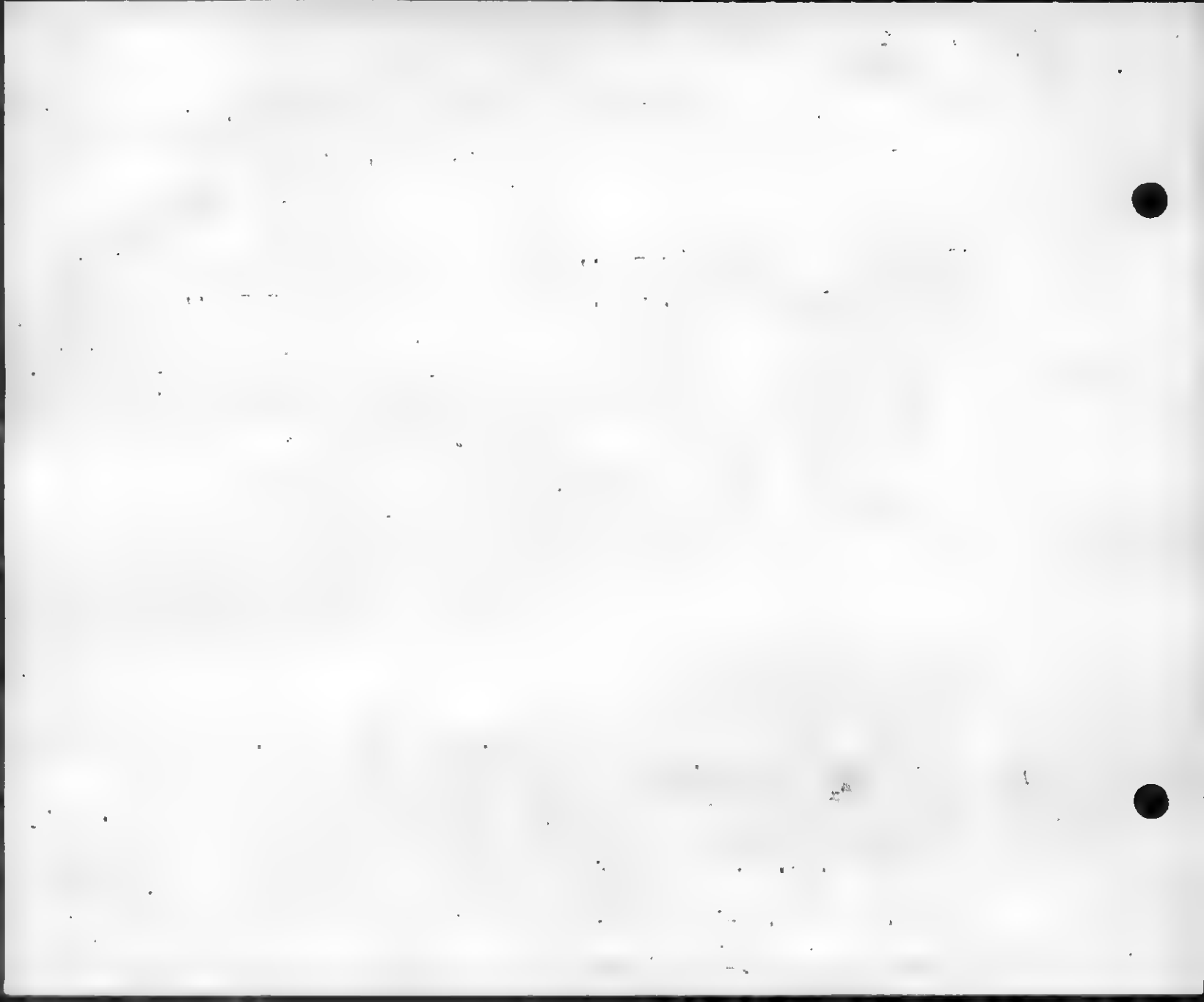
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

15

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
THERESA			DOROTHY	FITING	Month Day Year Mar. 21-1968			6:30		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		F. UNDER 1 YEAR		IF UNDER 24 HRS.
Female		White		Dec. 23rd, 1912		55 YRS.		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Washington		DC				Prince George		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Hillside			5803-L-St., SE			Housewife			none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Pr. Geo. Hillside					5803-L-St., SE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
John			Giovinazzo			Theresa Marie Caparotti				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
						Sister			Hillside Md.	
						Katie Petro			1102-58th Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										5 Hrs
4120 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) Hypertensive Arteriosclerotic										10 yrs
(c) Cardio Vascular Disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
1142										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
Where <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from Mar. 8, 1968, to Mar. 21, 1968, that (I) (we) last saw the deceased alive on Mar. 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
Dr. R. J. Terrafranca					Mar. 21-1968					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Dr. R. J. Terrafranca					#8 Barney Circle SE Wash DC					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 25-1968		Cedar Hill Cemetery			Suitland, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Simmons Bros					Wash DC			MAR 26 1968		
1661-Good Hope Rd SE										

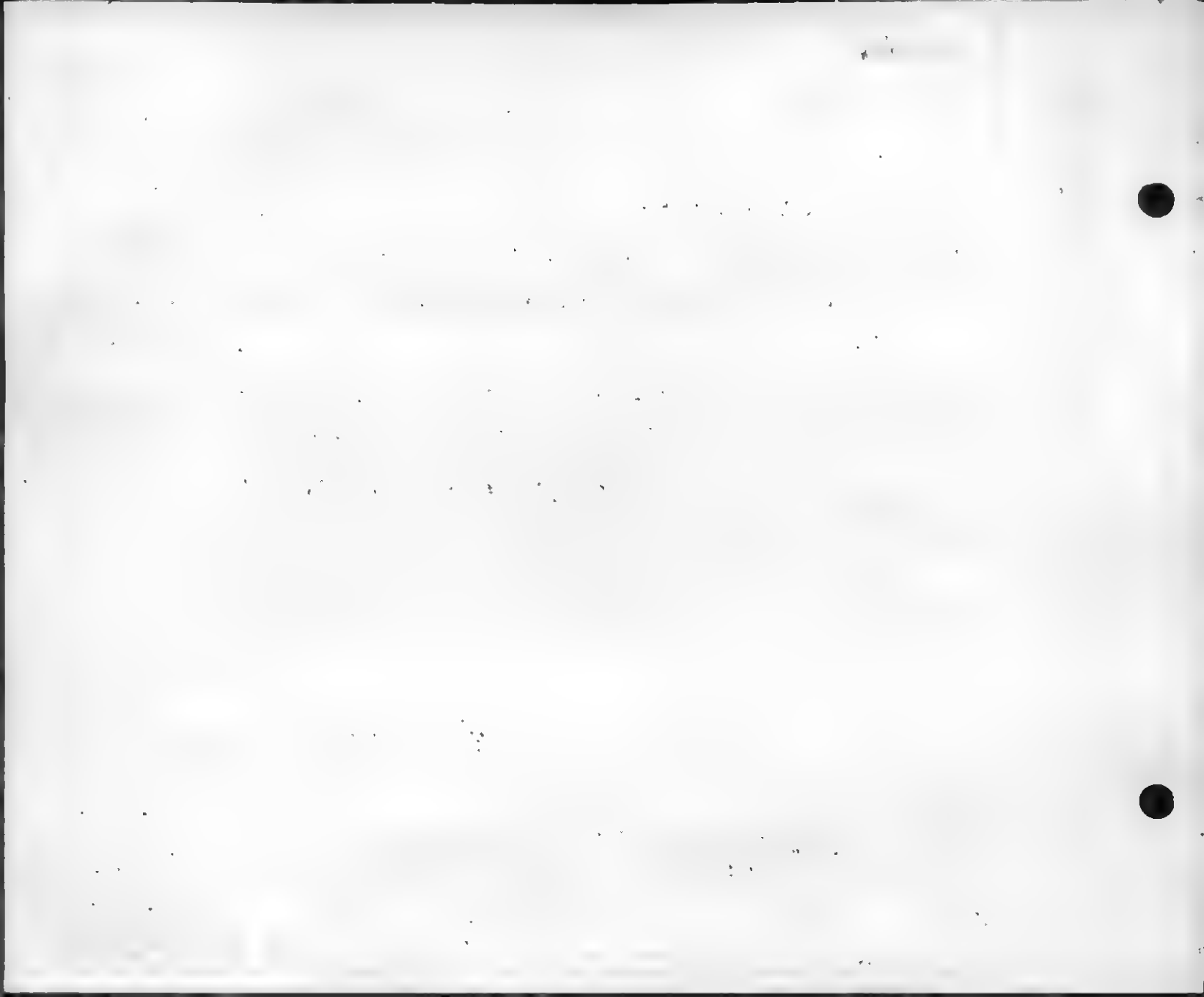




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MAY 264													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print) First Middle Last Lillian Erskine						2a. DATE OF DEATH Month Day Year March 27 1968			2b. HOUR P.M. 1:50				
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 7, 1871			6. AGE (In years last birthday) 96 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md							
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerical			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE District			13b. COUNTY Columbia			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 2101 -16th St. N.W.	
14. FATHER'S NAME First Middle Last John Erskine				15. MOTHER'S MAIDEN NAME First Middle Last Catherine Thayer Walker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 579-44-2052		17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal pulmonary edema</u> 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cardio vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 422													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19, 58</u> to <u>Mar 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>MAR 27 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>E. E. Quayle M.D.</u> DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <u>3-27-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>E. E. Quayle</u>				22e. ADDRESS <u>1822 Birchmore NW Washington</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Mar. 29, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newton Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Newton Center Mass.</u>							
24. FUNERAL DIRECTOR <u>H. Don. DeVol</u>				ADDRESS <u>2222 W'is. Ave N.W.</u>				25a. RECD BY REGISTRAR DATE <u>MAR 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

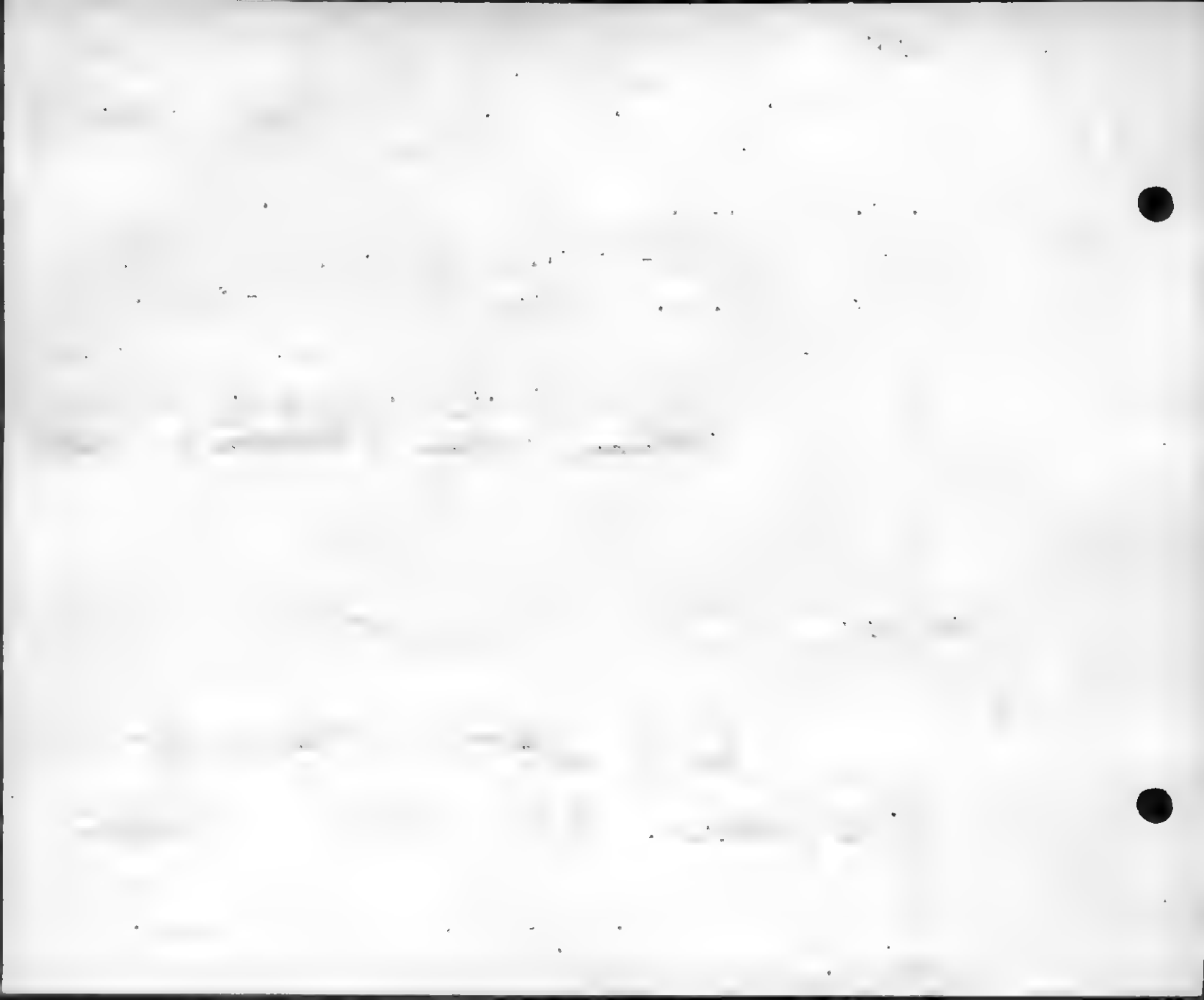


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Robert O. Evans</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>9:50 PM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>3/3/1921</b>		6 AGE (In years last birthday) <b>47</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>S.Car.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Pr.Geo.</b>	
10 CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>9210 - 6th St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Engr. Glendale Hosp.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr.Geo.</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>9210 - 6th St.</b>		14. FATHER'S NAME First <b>William</b> Middle <b>Evans</b> Last <b>Evans</b>		15. MOTHER'S MAIDEN NAME First <b>Louellar</b> Middle <b>Brooks</b> Last <b>Brooks</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WWII</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Vera S. Evans (Above address)</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion at home c. 12 months</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1</b>							
19a. DATE OF OPERATION <b>Oct-1967</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 2</b> , 19 <b>67</b> , to <b>May 18</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>May 14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		22c. DATE SIGNED <b>5/18/68</b>		22d. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22e. ADDRESS <b>[Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>3/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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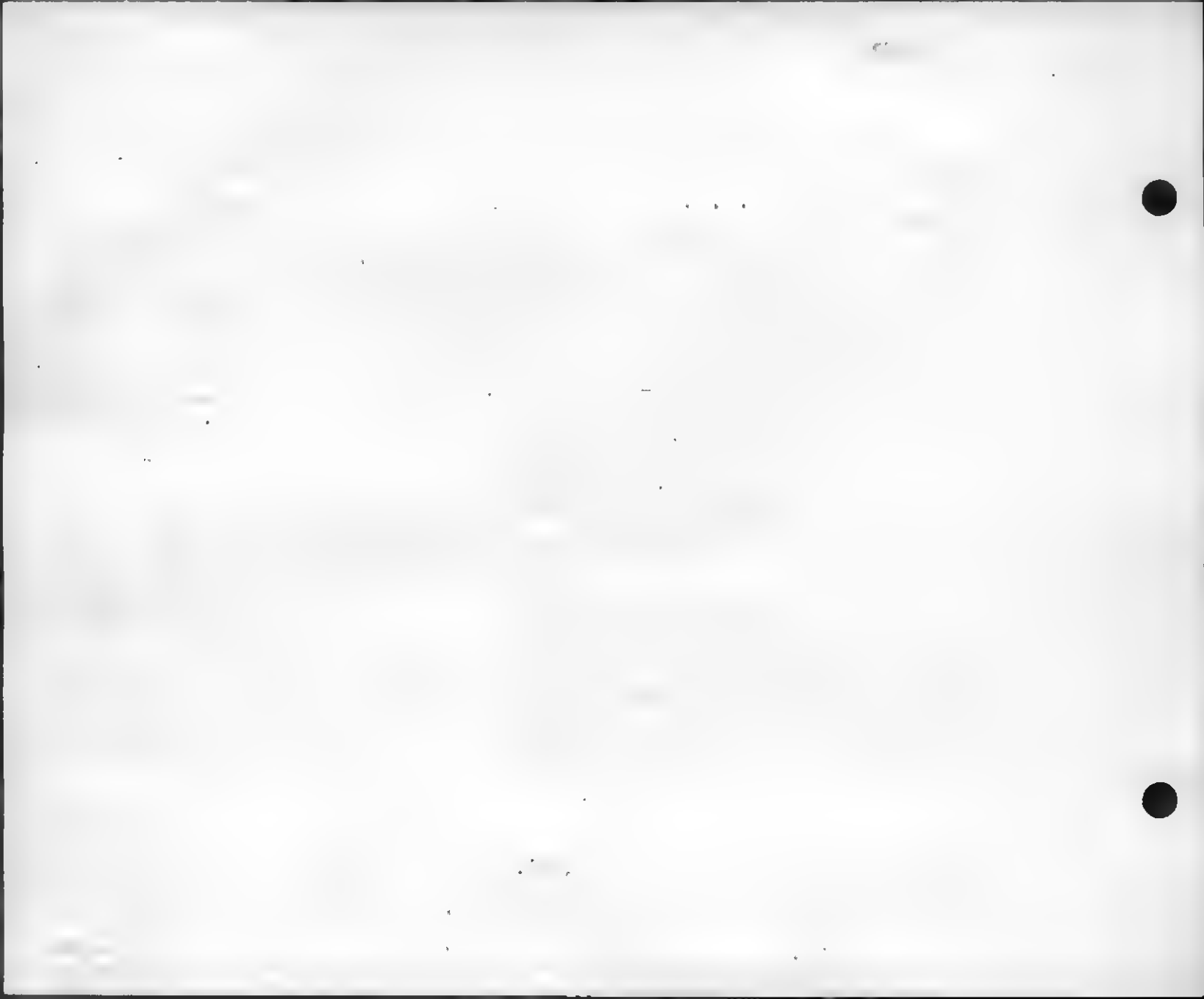
# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR					
Dorothy Jeanette Fairfax						Month Day Year			3-15-68 1968 00am					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR			
Female	White	5-21-1914	53 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	3 15 68 9:41am					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH								
Maryland		U.S.A.				Prince George's Md								
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George Hospital			Ret. waitress								
13a USUAL RESIDENCE (Where deceased lived if institution Res. since before admission)			13b CITY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Maryland			Prince George		Suitland		YES <input type="checkbox"/> NO <input type="checkbox"/>		5613 Shady Side Avenue					
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
William Henry Swann			Mary Emma Smoot											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT			ADDRESS						
No			578-26-9987		Mr. Mary E. Gignac - Pl., Riverdale, Md.			5409 - Morton						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										Md.				
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF Rheumatic valvular heart disease										over 3 yrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost														
(b) with mitral stenosis														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
			HOUR A.M. P.M. 19											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No.			City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
22b. DATE SIGNED														
3-16-68														
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
John Kohoe MD			Riverdale, Md.									ADDRESS (Street, city, town, or county)		
23a BURIAL CREMATION, REMOVAL, (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)		(County)		(State)		
Burial			3/18/68		Cedar Hill Cem.			Suitland, Md.						
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG. STRAR			25b REG. STRAR'S SIGNATURE					
Nalley's Funeral Home Inc.			Mt. Rainier, Md.			MAR 19 1968			Charles Judge					



FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301-W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year				2b HOUR OF ESTI- DEATH MATED <input type="checkbox"/> 3 14 15 1968	
Jesse		Moses		Ferrell									
3. SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
male	white	6-17-11		56 YRS						3 14 15 1968		10:30 P.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
N. CAROLINA		U. S. A.				Prince George's						Md	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USAL OCCUPATION (Kind of work done during most of working life even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Beltsville				11406 Hennessy Drive				TAXI CAB DRIVER				CAB CO.	
13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.				P.G.		Beltsville				11406 Hennessy Drive			
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last									
GEORGE				FERRELL				UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT		Ferrell ADDRESS 11406 HENNESSY DR BELTSVILLE, MD.					
YES				WW II		223-055135		MRS. VIRGINIA M. FERRELL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part or Port 2, Item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>													
22b. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 3-17-68					
22c. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>				ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>									
22d. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland				ADDRESS (Street, city, town, or county)									
EXAMINER'S NAME (Type)													
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
BURIAL				MAR. 18 1968		FT. LINCOLN CEM.		COLEMAN MANOR MD.					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
W.W. CHAMBERS CO.				RIVERDALE, MD				DATE MAR 22 1968		John Kehoe M.D.			





FOR STATE  
HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

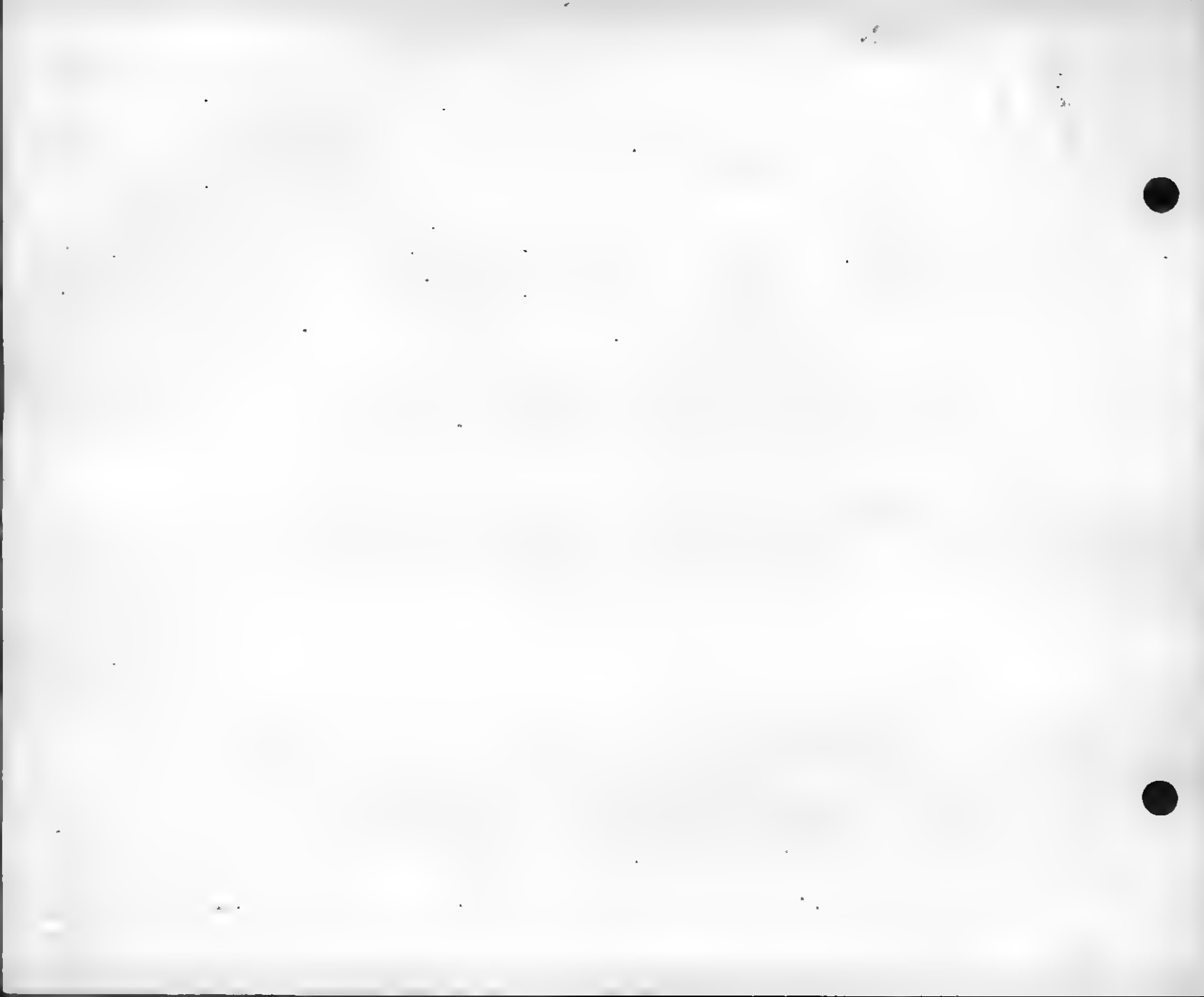
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04568

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>FZRA</b>			First Middle Last <b>FISHER</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>March</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>M</b>			
3 SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>May 25 1916</b>		6. AGE (In years last birthday) <b>51</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>New York City, USA</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges Md.</b>		
10. CITY OR TOWN OF DEATH <b>Chesley</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges General Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution of residence before admission) STATE <b>NY</b> COUNTY <b>MONROE</b>				13b. CITY OR TOWN <b>Chesley</b>				13c. INSIDE CITY OR TOWN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13d. STREET AND NUMBER <b>2290 St Paul Blvd</b>		
14. FATHER'S NAME First <b>Lewis M</b> Middle <b>Fisher</b> Last <b>Fisher</b>				15. MOTHER'S MAIDEN NAME First <b>Rachel</b> Middle <b>Karmensker</b> Last <b>Karmensker</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>Yes WWI</b>				16b. SOCIAL SECURITY NO <b>109-364167</b>				17. INFORMANT <b>Milton Fisher</b> ADDRESS <b>same</b>				
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>10 min</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4/10/1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201 Stomach ulcers</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Dayton O Watkins</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>3-30-68</b>				
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HT. HOPE CEM.</b>				23d. LOCATION (City or Town) <b>ROCHESTER</b>		(County) <b>N.Y.</b> (State)		
24. FUNERAL DIRECTOR <b>GOLDBERG FUNERAL HOME</b>				ADDRESS <b>4217-9th St. N.W.</b>				25a. REC'D BY REGISTRAR <b>APR 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



# FOR STATE HEALTH DEPT.

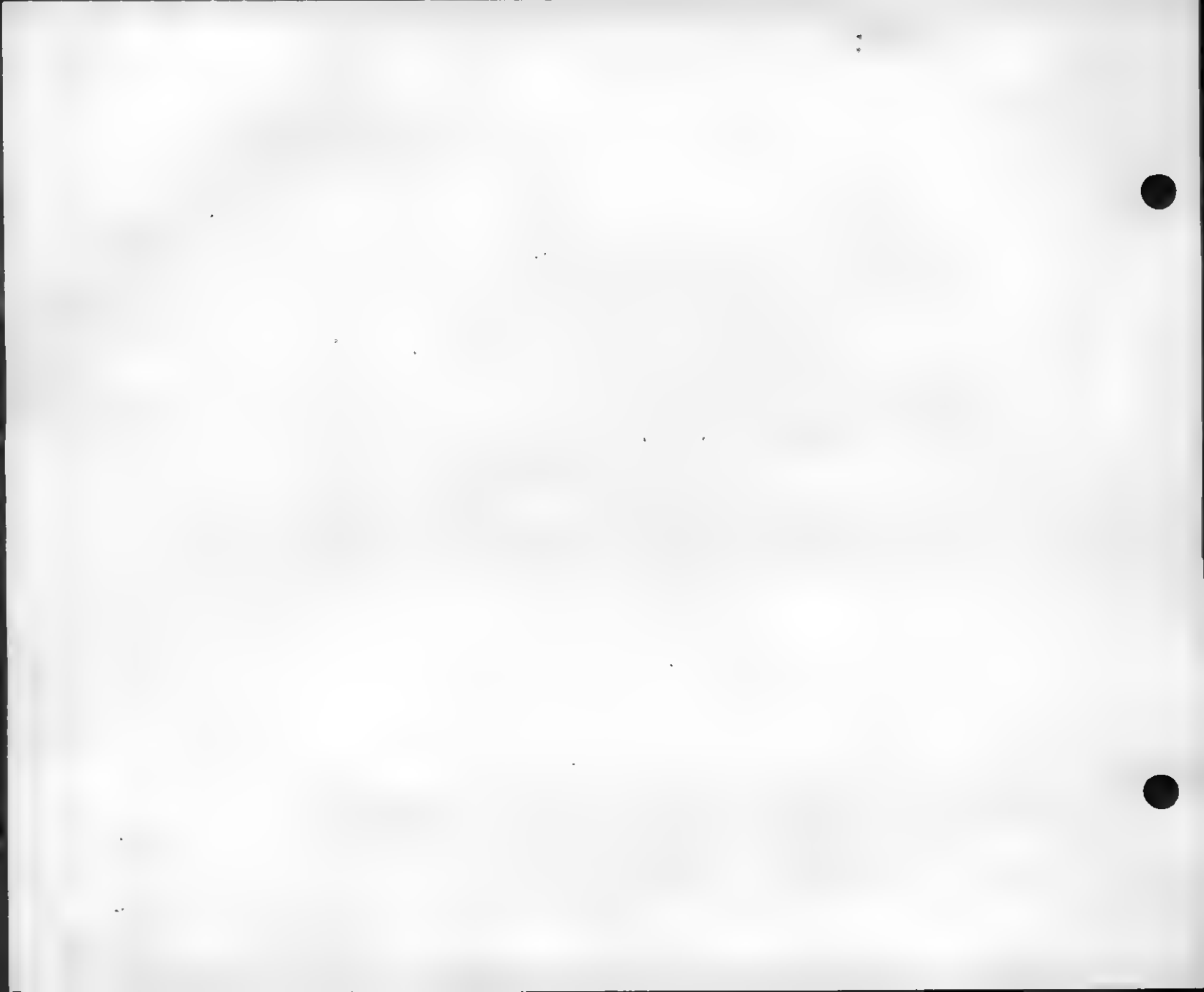
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 415ME  
10M REV 1-68

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH Month Day Year				2b. HOUR	
Lisa		Fletcher						3-18-68 19 8:30a M					
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Female	Negro	3-10-1962		6 YRS						3 18 68 19 8:30am M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Md.						Prince George's		Md					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly				Prince George Hospital									
13a. USUAL RESIDENCE (Where deceased lived 1 year or more before admission) STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER	
Maryland				Prince George's Capitol Heights								103 61st. Place	
14 FATHER'S NAME First Middle Last				15 MOTHER'S M A D E N NAME First Middle Last									
Louis Bernard Fletcher				Barbara Jean Hawkins									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17 INFORMANT ADDRESS					
								Louis Bernard Fletcher - Father					
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Irreversible brain damage													
DUE TO, OR AS A CONSEQUENCE OF Anoxia													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to inhalation of smoke													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:55am 3-13-19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Trapped in house fire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home				21f. LOCATION Street or RFD No City or Town County State same as # 13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)				22b. DATE SIGNED 3-18-68	
John Kehoe MD				Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)	
				3-23-68				Mt. Calvary				Forestville Md	
24 FUNERAL DIRECTOR				ADDRESS				25a. RECEIVED BY REGISTRAR DATE				REG. STATE SIGNATURE	
H.S. Washington & Sons				4925 Deane AVE				MAR 21 1968				James Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH				2b. HOUR	
Shelaline		Jeane		Fletcher		3-13-68 192:15pm							
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD				2d. HOUR			
Female	Negro	5-27-65	2 YRS	MONTHS	DAYS	Month 3 Day 13 Year 68 192:15pm M							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Md.		U.S.A.		Prince George's Md									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince George Hospital										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
Maryland			Prince George			Capitol Heights			103 1st. Place				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Louis B. Fletcher			Barbara Jean Hawkins										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS							
No						William E. Fletcher - Forestville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Smoke inhalation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>770X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>716.0</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month Day, Year 10:55am 3-13-1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) trampled in house fire							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) Home			21f. LOCATION Street or R.F.D. No. City or Town County State same as # 13							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 3-14-68				
John Kehoe MD			Riverdale, Md.			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
13-18-68			13-18-68			Mt. Calvary Ch. Forestville, P. Geo., Md.							
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Henry L. Mackington & Sons - Deane Ave., NE			4925			MAR 19 1968			James J. ...				

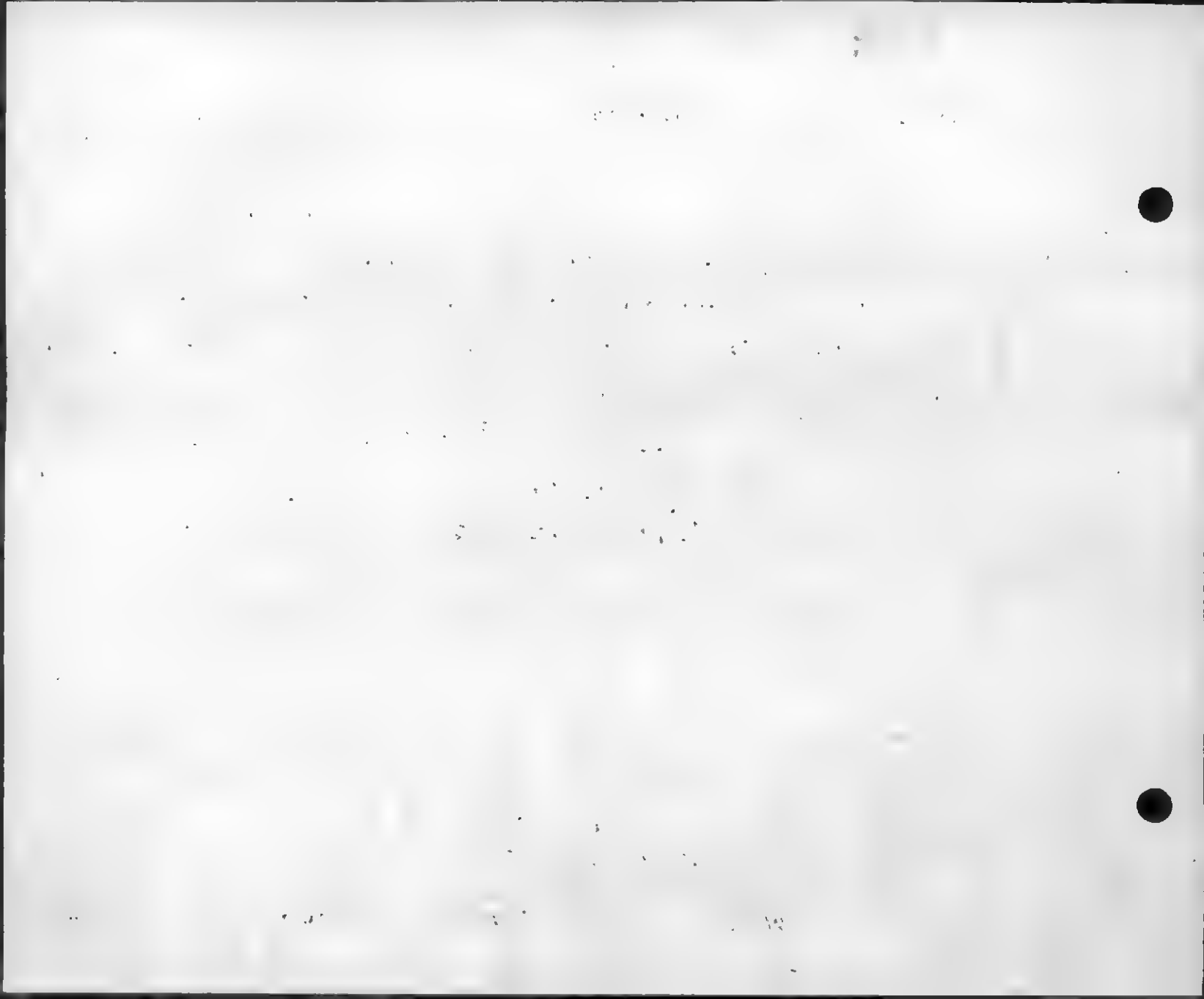


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Hanora (Hallie) Catherine Ford</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>1</b> Year <b>68</b>			2b. HOUR <b>4:35</b> AM				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8/31/82</b>		6. AGE (In years last birthday) <b>86 65</b> RS.		7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CIT. ZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Pr. Geo.</b> Md				
10. CITY OR TOWN OF DEATH <b>Clinton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Gardens</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>R.N.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>College Pk.</b>		13d. INSIDE CITY, LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5006 Cree Lane</b>	
14. FATHER'S NAME First Middle Last <b>Patrick J. Carroll</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sue Franklin Kerrick</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>229-28-5707</b>		17. INFORMANT <b>Daughter</b>		Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardiovascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-6 hrs.</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>42</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>1-27</b> , 19 <b>68</b> , to <b>3-1</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3-1</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Alfred R. Laper</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22a. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPER</b>						22e. ADDRESS <b>Clinton, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Richmond Riverview</b>		23d. LOCATION (City or Town) (County) (State) <b>Richmond Virginia</b>				
24. FUNERAL DIRECTOR <b>D. O. Williams</b>						25a. REC'D BY REGISTRAR <b>120</b>		25b. REGISTRAR'S SIGNATURE <b>James J. ...</b>		





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 2, 3 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

72 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

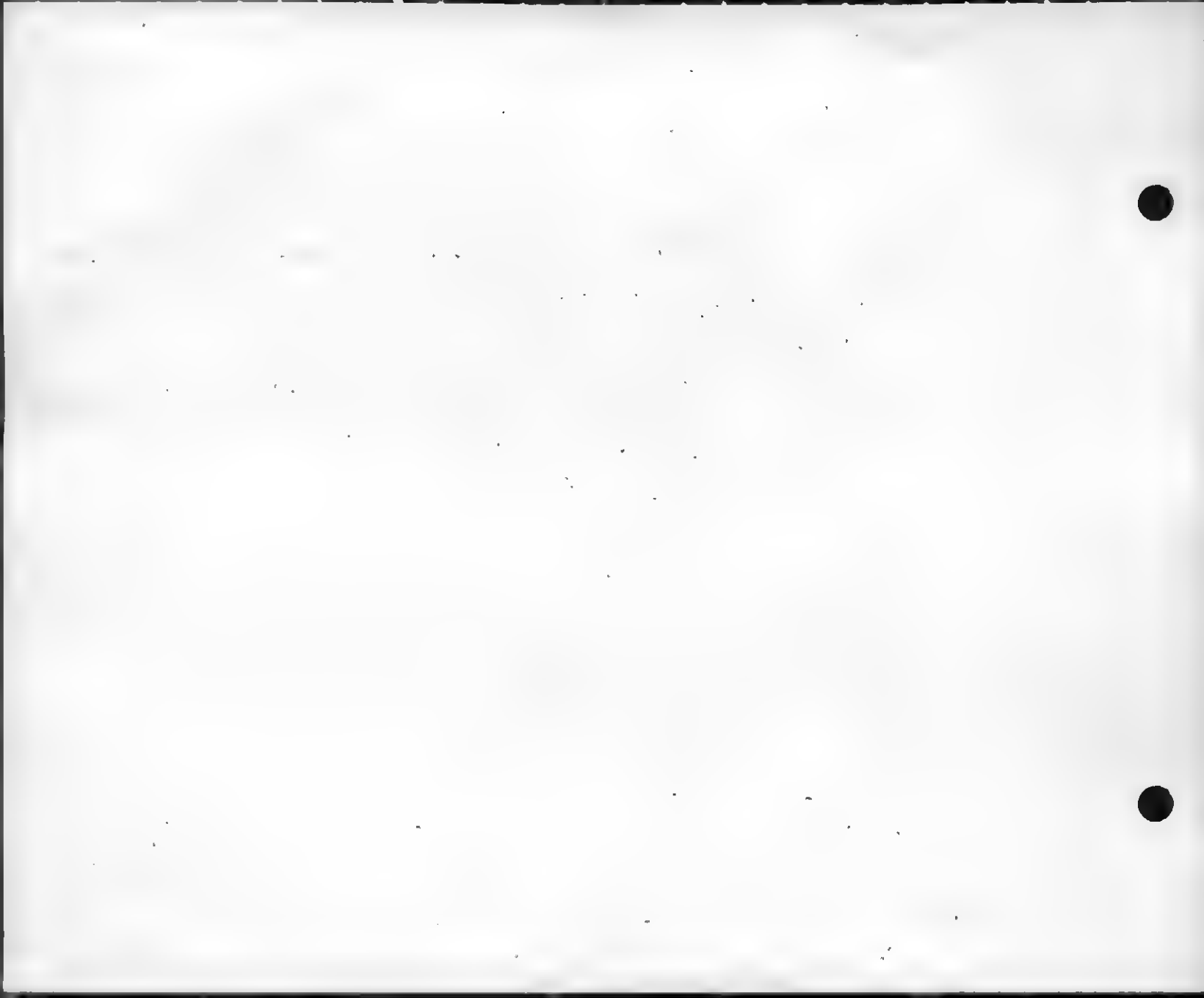
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Samuel Irvin Forsht Sr.						ESTIMATED DATE <input checked="" type="checkbox"/> 3-9-68			19 10:00am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	10 Sept. 1887	80 YRS					Month Day Year 3 9 68			10:30am
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Pennsylvania			USA						Prince George's Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Retired-U. S. Govt.					
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER		
Maryland			Prince George's Accokeek			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rt. 1, Box 233		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Samuel I. Forsht			Annie Bailey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
no						Mary E. Forsht--Accokeek,			Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> (b) <u>And Mycosis fungoides</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 2 yrs.</u> <u>over 2 yrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>3-10-68</u>		
<u>John Kehoe MD</u>			Rivendale, Md.			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL, SPECIFY			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-12-1968			Cedar Hill Cemetery			Suitland, Maryland		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Simmons Bros.			Wash DC			MAR 12 1968			Charles Judge		
1661-Good Hope Rd SE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR M		
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO		
17 INFORMANT			Address			18a. DATE OF OPERATION			18b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)			22a. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		
22a. I certify that (I) (this hospital) attended the deceased from Feb. 18, 1968, to March 16, 1968, that (I) (we) last saw the deceased alive on March 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATOR			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		

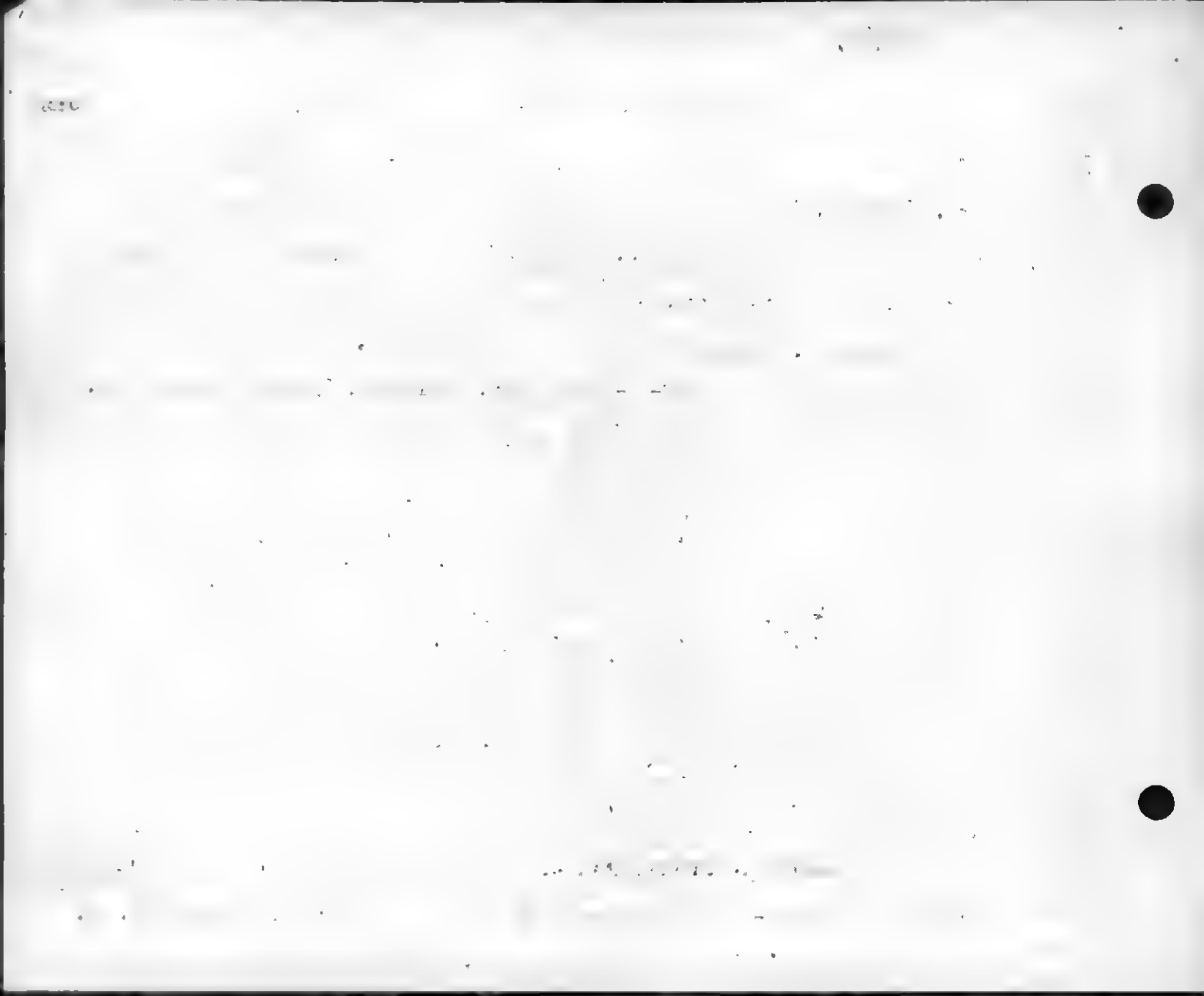


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02574  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>Marshall Thomas Gaither</b>			2a DATE OF DEATH Month <b>19</b> , Day <b>19</b> , Year <b>1968</b>		2b HOUR A. <b>10:50</b> M.
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH <b>5/12/1966</b>		6 AGE (In years lost birthday) <b>1</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Mont. Laytonville</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>Farming</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admiss on) STATE <b>Maryland</b>	13b COUNTY <b>Prince Georges</b>	13c CITY OR TOWN <b>Clinton</b>	13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>7901 Stewart Lane</b>	
14. FATHER'S NAME First Middle Last <b>George E. Gaither</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Olivia Layton</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>212-15-8206</b>	17 INFORMANT Address <b>Mrs. William E. Gaither Wheaton, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>High output renal failure</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>durianoma hernia repair, vesiculation plus SE bleeding</b>					
19a DATE OF OPERATION <b>2-16-68</b>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Benign prostatic hypertrophy</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING CAUSE OF INJURY <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b INJURY OCCURRED (Date and time of injury in Part 1 or Part 2, Item 18.) <b>Right thigh and arm</b>			
21d INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. <b>at home</b>	21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 24, 1968</b> to <b>March 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>March 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <b>Manuel V. Penasales</b>		22c DATE SIGNED <b>3-20-68</b>		22d PHYSICIAN'S NAME (Type) <b>Manuel V. Penasales, M.D.</b>	
22e ADDRESS <b>Prince Georges General Hospital, Cheverly,</b>		22f ADDRESS <b>Prince Georges General Hospital, Cheverly,</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE <b>3-21-68</b>	23c NAME OF CEMETERY OR CREMATORY <b>Laytonville</b>	23d LOCATION (City or Town) (County) <b>Laytonville, Mont. Md.</b>	23e REC'D BY REGISTRAR <b>Francis H. Barber</b>	
24 FUNERAL DIRECTOR <b>FRANCIS H. BARBER</b>		ADDRESS <b>LAYTONVILLE</b>		25a. REC'D BY REGISTRAR <b>MAR 26 1968</b>	25b REGISTRAR'S SIGNATURE <b>Francis H. Barber</b>



FOR STATE  
HEALTH DEPT.

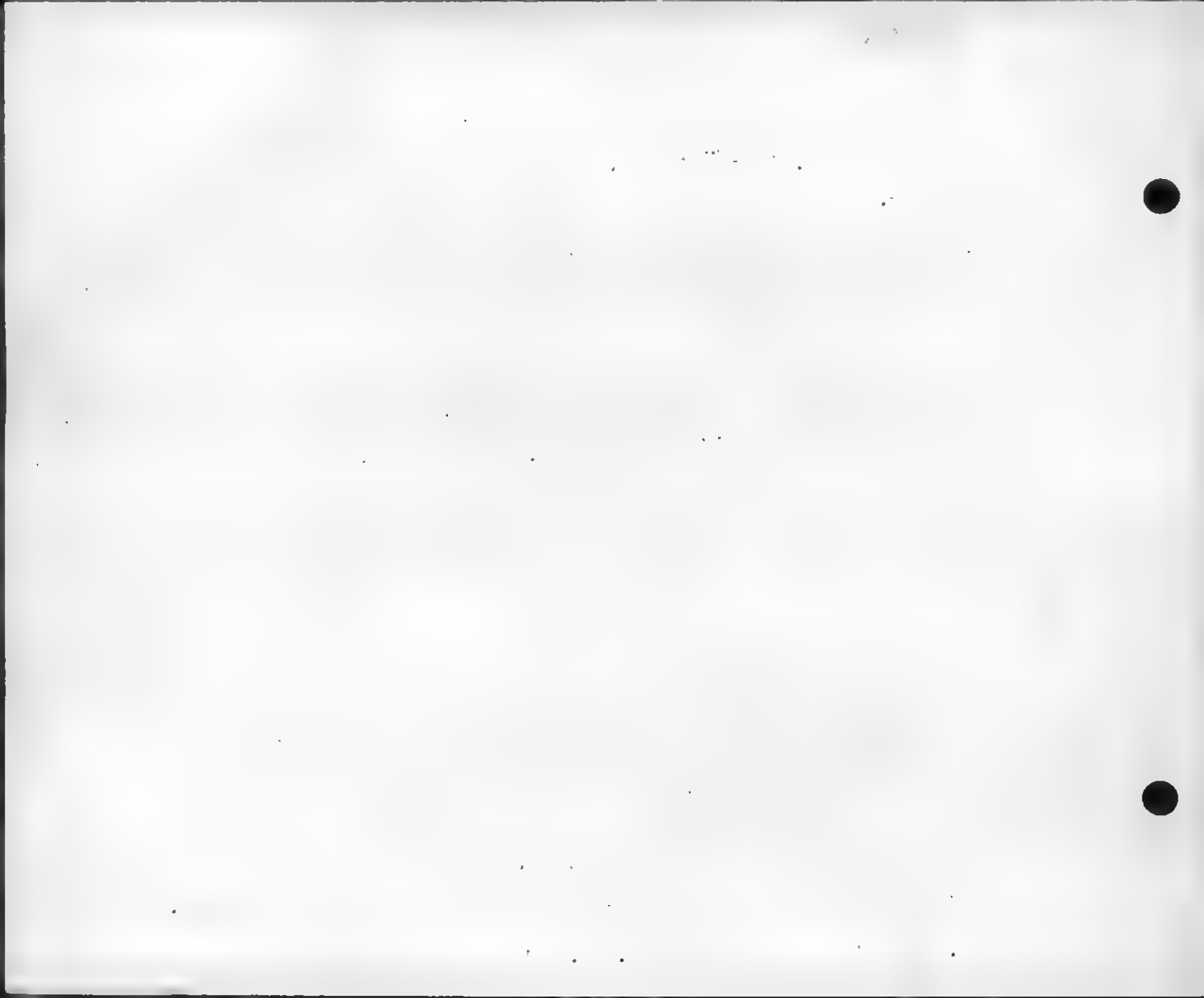
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2575

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
Cara Mae Gallagher						Month Day Year			24 45pm			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE in years (last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Female	White	April 4, 1880	87 YRS					Month Day Year			3:00pm	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
Penn.			USA						Prince George's Md.			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY
Cheverly				Prince George Hospital				Housewife				Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland				Prince George		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4 05 69th. Place		
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last			
Miller						UNK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT ADDRESS				
no				UNKNOWN				Mr. Paulin (Funeral Dir) Reading, Penna				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>inues</u> <u>over 5 yrs.</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>4200</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			2 b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH			19									
2 d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) <u>John Kehoe MD</u> Riverdale, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3-18-68			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Type or Print)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial/Removal				3/19/68		Park Forest Hills Memorial			Reading, Penna.			
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			
Jos. Gawler's Sons						5130 Wisconsin Av., NW Wash. DC.			DATE MAR 21 1968			
									25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			





FOR STATE  
HEALTH DEPT

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04570 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			2b. HOUR		
Baby Boy			Garner			Month Day Year			2:30 A		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
male	negro	3/17/68	YRS.	MONTHS	DAYS	Month Day Year			2:50 A		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Md.			U.S.			Prince Georges			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Georges General Hosp.			none			none		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Prince Georges Hyattsville			YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
									2802 Forest Terraces		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Robert Junior Butler			Margaret Louise Garner			no			none		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mother			same			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Apporx. 6 mo. 500 grm.					
						DUE TO, OR AS A CONSEQUENCE OF (b)					
						DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
226 X									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)		
ACTUAL SIGNATURE John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) John Kehoe			ADDRESS			3-19-68					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
			3/23/68			Prince Geo General Hosp.			Cheverly, Maryland		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John H. Penn, Jr., ADMINISTRATOR			MAR 27 1968			J. H. Penn, Jr.					

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March 17, 1964  
Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.  
Very truly yours,  
[Signature]  
[Title]  
[Organization]

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

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Item 13 film 398 3-14-68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

04577

04577

1. DECEASED-NAME (Type or print) First Middle Last EDWINA GONZALES			2a. DATE OF DEATH MAR Month 2 Day 68 Year			2b. HOUR 2 00 5 M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 3 OCT 40		6. AGE (In years lost birthday) 27 YRS.	
7a. BIRTHPLACE (State or foreign country) NEW MEXICO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S Md.	
10. CITY OR TOWN OF DEATH ANDREWS AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASH. D.C. Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN WASH. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2444 ROCHELLE AVE.		14. FATHER'S NAME First Middle Last ERMINIO GUTIERREZ		15. MOTHER'S MAIDEN NAME First Middle Last CLARINDA JARAMILLO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 525-84-7087		17. INFORMANT SGT ELIZARDO GONZALES		Address SAME AS ITEM #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA & SEPTICEMIA 734.1 DUE TO, OR AS A CONSEQUENCE OF (b) SYSTEMIC LUPUS ERYTHEMATOSUS DUE TO, OR AS A CONSEQUENCE OF (c) 456X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) LEUKOPENIA AND THROMBOCYTOPENIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 5 Feb, 1968, to 2 Mar, 1968, that (X) (we) last saw the deceased alive on 2 Mar, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Burton Sack				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2 Mar 68	
22d. PHYSICIAN'S NAME (Type) BURTON SACK, CAPT USAF MC				22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/8/68		23c. NAME OF CEMETERY OR CREMATORY Sedillo Cemetery		23d. LOCATION (City or Town) (County) (State) Bernalillo County, New Mexico	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR DAMAR 8 1968		25b. REGISTRAR'S SIGNATURE Charles Yunge	

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THE 10th 1947

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